Institut européen
European Institute

LUISS
School of Government

Joint Master in Global Economic Governance and Public Affairs

Analysis of Human Rights Indicators and Evaluation of their Effectiveness as Measurement Tools to Assess Maternal Health Conditions

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2023

Statutory Declaration

I hereby declare that I have composed the present thesis autonomously and without use of any other than the cited sources or means. I have indicated parts that were taken out of published or unpublished work correctly and in a verifiable manner through a quotation. I further assure that I have not presented this thesis to any other institute or university for evaluation and that it has not been published before.

June 11th, 2023 *Janes, Daphne*

Acknowledgements

I would like to acknowledge and give my warmest thanks to my thesis supervisor Cristina Teleki. Her advice and guidance has helped me through all of the stages of writing, and her feedback and expertise has been invaluable to my thesis. I would like to thank her for encouraging my research and pushing me to grow as a student and writer. Secondly, I would like to express my gratitude for my fellow classmates. Their constructive critiques throughout this process and their kind friendships are greatly appreciated. Lastly, I would like to acknowledge and thank my family for their loving support and encouragement to pursue this masters degree in the first place. This thesis would not be possible without all of you.

Abstract

This report provides a brief overview of the history of international human rights, as well as discusses certain key supranational treaties that have served as foundational elements to the formulation of international human rights law. The report expands on these notions by analyzing the purpose behind the United Nations' proposal for Human Rights Indicators (HRIs), which aim to serve as a framework to assist human rights stakeholders in their development of measurement tools for human rights standards. The report assesses the positive and negative attributes of the HRIs, and highlights challenges to the creation and implementation of the HRIs.

To demonstrate the level of effectiveness of the HRIs, the report narrows its focus to maternal health conditions, as maternal health can serve as an important indicator of the overall state of human rights practices, as well as the extent of human rights violations, within a region. This report analyzes maternal health quality in the United States and the Netherlands to further highlight the need to prioritize maternal health and maternal healthcare in all countries, regardless of their development status. It aims to evaluate these conditions by utilizing HRIs, thereby serving as an example of how HRIs can be applied in maternal health-specific scenarios.

This report finds that HRIs can facilitate the human rights' measurement process; however, the limitations that the use of HRIs presents, specifically in regard to health-related and maternal health-related human rights practices, are numerous and varied, affecting their effectiveness, sufficiency, and accuracy. Moving forward, these factors must be considered and mitigated by human rights stakeholders in order to best evaluate human rights conditions.

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Introduction

Human rights are considered inherent to all human beings, regardless of race, sex, nationality, religion, or other personal characteristics, and everyone is entitled to such rights without prejudice or discrimination (Donnelly & Whelan, 2020). Ensuring human rights enjoyment and minimizing infringements on human rights concerns all people around the globe and must be prioritized. A world without human rights is a world in which the very essence of humanity and civility are called into question and where oppression and injustice win out over community and peace. According to the United Nations, without human rights, "little by little, this toxic rises around us, and those vital deep principles that safeguard peaceful societies risk being washed away" (OHCHR, 2019, p. 6). And, rightfully, countries that do not protect their citizens' human rights suffer politically, socially, and economically, and should be held responsible by other countries via sanctions and other methods, as well as by international tribunals via prosecutorial means. International human rights laws work to support and implement human rights standards, and international human rights courts ensure accountability for actors violating such standards. But these accountability methods to ensure human rights protections are only effective if a means of assessing human rights conditions exists in the first place (Lauren, 1998).

One of the most appropriate tests of good global governance is the ability of a state and its agents to deliver upon promises and obligations to ensure human rights in a manner "free of abuse and corruption and with due regard for the rule of law" (OHCHR, 2021, "About good governance"). Given the resulting need for stakeholders, national and international activists, governments, and policy makers to adopt human rights-specific measurement tools, the Office of the High Commissioner for Human Rights (OHCHR) of the UN has developed a framework to govern the creation and implementation of human rights-specific indicators. Human Rights Indicators (HRIs) were first proposed by the inter-committee meeting of the OHCHR in 2006 and fully adopted in 2012 as a means to assess compliance by duty bearers with existing human rights treaties. They were created to prevent violations of human rights, to secure respect for all human rights, to protect human rights, to promote international cooperation, to coordinate related activities throughout the

UN, to strengthen and streamline the UN's work for human rights, and most importantly, to ensure accountability for human rights violators (OHCHR, 2012).

While national governments and other human rights stakeholders and donors across the world continue to apply the OHCHR's *Human Rights Indicators: A Guide for Measurement and Implementation* as a comprehensive guide to help achieve human rights in all capacities, these HRIs remain a mere guideline. Oftentimes the choice of indicators, methods, and data collection process is left to the discretion of each country, creating wide gaps in data aggregation and even wider gaps in the protection of human rights imperatives. "Declarations, principles, guidelines, standard rules and recommendations [regarding the HRIs] have no binding legal effect…", and the obligations "should be translated into policies and measures that define and facilitate the implementation of human rights" (OHCHR, 2012, p. 14).

This report aims to assess the ability of HRIs to appropriately, accurately and sufficiently portray human rights conditions as they propose to do, by evaluating their positive attributes, as well as their limitations. To demonstrate the scope of HRIs – their effectiveness as proxies for a wide range of human rights – this report evaluates their applicability in the United States and the Netherlands to maternal health conditions, as well as their ability to measure such conditions, as maternal health can serve as an important indicator of the overall state of human rights practices. This focus on human rights relating to maternal health suggests that the degree to which a country mitigates human rights violations directly reflects human rights conditions within a country.

Literature Review

The primary source used in this report is *Human Rights Indicators: A Guide for Measurement and Implementation,* created by the OHCHR, which serves as the official framework proposed by the UN for human rights-related indicator creation and implementation. Further sources that guide this report include the Universal Declaration of Human Rights and its two optional covenants, the International Covenant on Economic Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). Together, these comprise the International Bill of Human Rights, which details the foundational elements necessary to international human rights and international human rights law. The journal article Human Rights Indicators and the Sovereignty of Technique (2016) by McGrogan for the *European Journal of International Law* facilitated the analysis of the limitations and positive features presented by the HRIs.

With regard to health- and maternal health-related literature, the majority of this report utilized recommendations and findings produced by the World Health Organization (WHO), the Centers for Disease Control (CDC) and the National Institute of Health (NIH). These institutions are highly reputable in the health and public health sectors, and their research and studies are of high caliber and reliable. The WHO produces findings at the national and international level, while the CDC and NIH produce findings specific to the United States. Two in-depth studies conducted by experts in the field of health and public health, Salempessy et al. and Rodriguez et al., guided the analysis included in chapters 4 and 5 discussing the role of indicators as tools for measurement in health- and maternal health-related fields. Further, a study conducted by Tikkanen et al. provided detailed cross-country comparisons of maternal health conditions in 10 developed countries, facilitating the discussion in chapter 6 regarding the case study of maternal health standards in the US and the Netherlands.

The existing literature and research regarding HRIs, including but not limited to their intended purpose, history, and evidence of use by stakeholders, are somewhat narrow in scope and variety. This may be due in part to the relative newness of the HRIs, as the OHCHR published the guide to HRIs in 2012. Research in this field may have also been disrupted or affected by the Covid-19 pandemic. Further, this report's focus on maternal

health only allowed for the analysis and inclusion of health-related HRI findings, thereby restricting the use of other, broader HRI findings. Additionally, research for this report found that many health organizations do, in fact, utilize indicators as tools for measuring human rights, but do not specifically refer to these indicators as HRIs. Similarly, they often utilize indicators that meet some but not all three objectives of the HRIs. Thus, findings from these sources could not be included, as their relation to HRIs was unclear.

Methodology/Methods Applied

This report utilizes the framework proposed by the OHCHR's *Human Rights Indicators* as a means to understanding the creation and implementation of HRIs as they were initially designed. Specifically, this report focuses on the three objectives that HRIs must fulfill to evaluate the effectiveness of HRIs as measurement tools for human rights conditions. These objectives, as described by the *Human Rights Indicators,* are an indicator's ability to 1) portray quantitative and fact-based analysis; 2) accurately identify attributes that link normative human rights standards with the appropriate human right; and 3) follow the structure-process-outcome model of indicator selection (OHCHR, 2012).

The maternal health-related data included in this report utilizes the definitions and proposals of the WHO and commonly refers to maternal mortality and morbidity rates as primary indicators of maternal health standards in a particular region. This report relies on both quantitative and qualitative analysis to assess HRIs and their usage.

The data in the maternal health case study, discussed in chapter 6 of this report, is from the World Bank, CDC, UNICEF, WHO, and relevant governmental publications. The case study applies the framework laid out in the OHCHR's *Human Rights Indicators* to assess maternal health standards in the US and the Netherlands. The tables included in the case study follow the HRI framework; however, they were specifically created for the purposes of this report and do not exist in outside literature. The case study strictly adheres to the objectives outlined in the *Human Rights Indicators* in order to demonstrate potential use of the HRIs in a health-related setting.

Chapter 1 - Human Rights

1.1 – History of Human Rights

Human rights and human rights law aim to identify, protect and guarantee the foundational and fundamental values cherished and upheld by cultures around the world regarding the state of personhood. While these rights are intrinsically linked to the idea that all persons share certain qualities and characteristics of humankind that cannot be infringed upon by either individuals or institutions, instances of discrimination and persecution based on a person's possession, or lack, of certain characteristics, span the ages. Such discrimination largely results from direct and indirect prejudices based on differences in race, sex, nationality, ethnicity, language, religion, or other identifying personal characteristics. To mitigate violations of these human rights and maximize their enjoyment, acknowledgement and legal protection is essential at both the regional and international levels (United Nations, n.d.-b).

This exigency at the international, and not solely the state level, became evident following World War II. The atrocities that occurred in World War II, including the discrimination based on religion, nationality, and sexual orientation that resulted in mass genocide throughout Europe, highlighted an increasing need to protect human rights on a global level, and to universally recognize human rights standards and protocols (Bates, 2010). Until this time, human rights infringements were a matter for national governments, not supranational and international institutions. This necessity to create and implement international human rights law has only increased as the world becomes ever more globalized, and countries become ever more interconnected (OHCHR, 2012).

Following World War II, countries around the world began to recognize the crucial need to safeguard human rights, as a way to prevent these brutal acts from occurring again, anywhere throughout the world. Creating such safeguards required a comprehensive body of international human rights standards, which would need to be ratified by most, if not all, countries in order to ensure adequate human rights protections. To logistically implement assurances at the international level, a distinction between who holds the human rights and who must protect them was identified. To distinguish rights holders from duty bearers and to identify the rights inherent to personhood, the UN set out to develop a set of international

human rights practices for all nations to subscribe to and all people to aspire to (United Nations, n.d-a.).

1.2 - International Human Rights Treaties

The Universal Declaration of Human Rights (UDHR) was drafted by the UN in 1948 following the conclusion of World War II, as the human rights violations displayed during the war made clear that a framework to identify and protect human rights must be outlined and agreed upon by Member States in order to protect against future discriminations and inequities. The UDHR was created to highlight the universal, inalienable, indivisible, interdependent, equal, and non-discriminatory rights bestowed upon all persons regardless of gender, sex, sexual orientation, race, ethnicity, nationality, religion, cultural identity, or otherwise (Bates, 2010).

According to Hernán Santa Cruz, a member of the UDHR drafting sub-Committee, "…a consensus had been reached as to the supreme value of the human person…which gave rise to the inalienable right to live free from want and oppression" (United Nations, n.d.-a, "History of the Declaration"). The UDHR listed 30 articles specifying what was to be considered a human right, and additional rights have been identified in subsequent human rights documents, treaties, and general comments (OHCHR, 2020). The fundamental freedoms described in these bodies of work each place an essential value on every human life, guaranteeing that "all human beings are born free and equal in dignity and rights" (United Nations, 1948b, article 1). The creation and implementation of the UDHR has also encouraged many countries and coalitions of countries to establish their own national and international standards, treaties, and tribunals to further hold abusers of human rights accountable and facilitate a united front against discriminatory behaviors (European Court, n.d.).

While the ideology behind human rights was not new, the relationship between rights holders and duty bearers at the international level was. In this case, the UDHR identified state actors as having an obligation to "respect, protect and fulfill" the human rights of citizens and persons living within the boundaries of a given country in order to allow for the fullest enjoyment of being human. Thus, national stakeholders like government officials are considered to be the 'duty bearers' of international human rights

standards as they possess a duty to ensure the greatest fulfillment of human rights. In turn, the citizens and individuals residing in the state are considered the 'rights holders,' for they hold the rights in these circumstances (OHCHR, 2012). In the years since the UDHR was initiated, business enterprises and their respective corporate actors have been added to this group of duty bearers as they hold a similar obligation to comply with human rights laws and respect the human rights of their employees in the workplace. The OHCHR of the UN has expanded on these corporate standards in the *Guiding Principles on Business and Human Rights* (OHCHR, 2012, January).

In addition to the UDHR, two optional covenants, the International Covenant on Economic Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), were created in 1966, and the three documents now comprise the International Bill of Human Rights of 1948 (UN Research, n.d.). The Bill aims to more clearly and comprehensively identify the social, civil, political, economic, and cultural rights entitled to all people and further identifies the responsibilities of the the state and other duty bearers to adhere to three main obligations: to respect, protect, and fulfill these rights (United Nations, 1948a).

These obligations represent the pillars of human rights ideals and pertain to matters of conduct, matters of result, and matters of monitoring and reporting. The obligation of conduct requires duty bearers to take reasonable action to address human rights matters; the obligation of result requires duty bearers to actually achieve or make progress towards achieving certain targets created to fulfill the relevant human rights standards; and the obligation to monitor and report builds off of the obligations of conduct and result in that a duty bearer is obligated to delineate its efforts to address these standards. These three criteria ensure that a duty bearer is adequately meeting individual human rights needs and is acting in accordance with the human rights standards implemented by the Bill (OHCHR, 2012).

1.3 – Ensuring Equity among the Human Rights

While the UDHR recognizes 30 distinct human rights, each of these rights should be thought of as a piece to an elaborate puzzle, for human rights are interconnected and interrelated in nature. Just as a puzzle missing pieces is not complete, violation of some

human rights poses risk to the attainment of all human rights. Thus, every human right must be protected to an equal degree, as the degree to which one can enjoy a right is dependent on the degree to which all other rights are realized (United Nations, 1948b). To this end, the linked feature of human rights similarly demonstrates that addressing one human right by improving its protection and guaranteeing its enjoyment will indirectly benefit other human rights protections and guarantees. By virtue of this, all rights must be considered equal under international human rights laws, since maintaining such equality emphasizes the crucial notion that duty bearers cannot prioritize amongst the rights. In other words, duty bearers cannot forgo their commitments to certain rights in order to attend to other rights.

While this ideal is a foundational element to human rights practices, the UN does acknowledge a caveat. Given the fact that addressing all human rights at once may be an overwhelming task for some duty bearers and may require exorbitant funds and resources that are not immediately available in certain regions, the UN and its governing bodies recognize that certain states may need to progressively implement new human rights regulations. This progressive implementation process mitigates consequences related to premature or hasty decision making, which may exacerbate human rights issues in the future. This caveat especially pertains to developing countries that are grappling with a variety of human rights as well as developmental issues and cannot tend to all these concerns at once. Given this reality, the UN concedes that human rights protections may be addressed in stages as long as duty bearers maintain a "minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels [of human rights]." To do this, states must adequately demonstrate that they are, in fact, utilizing all available resources and that plans exist to progressively implement the necessary human rights practices (Söllner, 2007, p. 403).

While implementing new and improving upon existing human rights practices require time, political will, financial backing, and human capital – resources not readily available for all regions – certain rights, like civil and political rights, require less time and fewer funds for duty bearers to implement. For instance, once a state has ratified and guaranteed certain civil and political rights, individuals can almost immediately enjoy them. Other human rights, for instance the right to effective remedy and the right to equal

pay for equal work, may require not only more extensive structural reformation but also adjustments to social perceptions, as well as a multifaceted approach that will almost certainly take more time to implement and ensure. Nevertheless, the amount of 'work' that may be needed for state officials to address human rights infringements and better ensure enjoyment of said rights should not deter a government from taking on the task. Just as all human rights are equal, efforts toward attaining their fullest degree of enjoyment must also be considered equal (OHCHR, 2012; United Nations, 1948b).

Chapter 2 – Measurement Tools for Human Rights

2.1 – Human Rights-Specific Measurement Tools

While these international treaties have greatly facilitated human rights protections throughout the world, duty bearers must somehow be able to adequately assess human rights conditions within a region in order to identify areas to address. Hence, the need for measurement tools for this purpose. This section will assess the use of indicators, as well as other types of measurement, in human rights data collection.

The idea that numbers are the foundation to systematic knowledge traces back over centuries, for figures and measurements possess an element of objectivity that verbal statements and opinions inherently lack. This objectivity of numbers allows statisticians and users of statistics to make evidence-based decisions that are rooted in fact (OHCHR, 2012). In the human rights sector, numbers and figures similarly provide duty bearers and international bodies with impartial measurements that can be used to make human rights-related decisions. Relevant statistics allow countries and organizations to effectively manage populations and develop evidence-based decision-making protocols. Conversely, many human rights experts and advocates view the objective nature of numerical data as a limitation, believing numbers cannot be the sole descriptor of human rights conditions in a region. This perspective highlights the need for additional measurement tools (OHCHR, 2012).

While indicators in general have dominated the corporate world for centuries, they did not make the jump to the field of human rights until the late 1990s, when the Special Rapporteur on the Realization of Economic, Social, and Cultural Rights recommended that states consider measuring progress towards human rights realization by means of indicators (McGrogan, 2016; Merry, 2011). Before this time, human rights activists resisted using statistics to quantify human rights, attributing their concerns to lack of quality data, tendency toward oversimplification, and potential inherent bias (Merry, 2011).

Before human rights-specific indicators began to dominate the methodological field, monitors of human rights practiced a more ‘traditional’ approach to measurement, one rooted in narrative and often digressive in nature. These traditional measurements, while definitely comprehensive, took excessive time to formulate, were highly subjective and left

to the discretion of the statistician, and often lacked evidence of fact-based judgments, all factors which can negatively impact a government's ability to productively utilize the data. Now, to avoid the overly lengthy, descriptive, and biased nature of previous methodologies and to more correctly, clearly, and concisely report data findings, states increasingly opt to use quantitative and qualitative indicators, in a process that resembles an audit (McGrogan, 2016).

2.2 - Creation of the HRIs

According to the OHCHR's *Human Rights Indicators*, relevant stakeholders, including national and international activists, governments, and policy makers, have demonstrated an increasing need for human rights-specific indicators in order to make evidence-based assessments regarding current conditions of human rights in a particular region. Human Rights Indicators (HRIs) were first proposed by the inter-committee meeting of the treaty bodies of the OHCHR in 2006 as a means to assess duty bearers' compliance with existing human rights treaties. They were created to protect and secure respect for all human rights, to prevent violations to human rights, to promote international cooperation, to coordinate, strengthen and streamline the UN's work for human rights, and most importantly, to ensure accountability for human rights violators (OHCHR, 2012).

The proposed indicators were put to discussion by an international panel of human rights experts from a plethora of different backgrounds, including academia, governance and civil society. These discussions led to workshops and consultations throughout Asia, Africa, Latin America, Europe, and North America, to garner feedback that was then utilized by the OHCHR to make adjustments to the indicators. In 2012, once these steps were completed and the necessary adaptations were made, the OHCHR published the *Human Rights Indicators,* therein proposing changes to the existing national and international tools of human rights measurement. Since 2012, governing bodies, non-governmental organizations, and civil society organizations have increasingly used the HRI measurement tools to evaluate socioeconomic and political conditions related to human rights and the effectiveness of mechanisms governing human rights practices (OHCHR, 2012).

Typical statistical analyses in the field of human rights and human rights law are often too broad in scope, lack clarity, and only indirectly pertain to human rights-related events. HRIs, on the other hand, allow state actors to assess their own progress in protecting and ensuring the full extent and enjoyment of human rights in their region. HRIs thus serve as an essential link between the concepts of human rights theory and the logistics of human rights practices. They provide a systematic approach to translating human rights standards into measurements that are more easily understood, more easily compared, and more easily replicated (OHCHR, 2012).

While human rights standards and the obligations they bestow on duty bearers are not new concepts, the HRIs aim to reflect countries' regional values and concerns in the progress being made towards adequate human rights protections. This relation serves a two-fold purpose: it facilitates regional development and encourages good governance (OHCHR, 2012). More simply put, HRIs may be a new measurement tool, but the concepts they are rooted in are age-old.

Chapter 3 – Analyzing the HRIs

3.1 - Objectives of the HRIs

In order to better understand the use of HRIs, a thorough evaluation of the characteristics of indicators and an assessment of their objectives is necessary. The following section 1) analyzes the differences between types of indicators utilized in the HRI process; 2) compares the advantages and disadvantages of each type; 3) evaluates the connection between indicators and their intended purpose; and 4) explains the HRI generation process.

Three Main Objectives of HRIs

HRIs have three main objectives. The first objective encourages quantitative and fact-based measurements over qualitative and judgment-based measurements; the second objective links normative human rights standards to particular human rights attributes; and the third objective describes a structure-process-outcome model (OHCHR, 2012).

First Objective: Types of Indicators

With regard to the first objective, HRIs can be quantitative or qualitative; however, quantitative indicators are preferred. Quantitative indicators are numerical or categorical and measure a topic in terms of numbers, percentages, indices, or time frames. Quantitative measurements allow for evaluations of magnitude and facilitate quick comparisons between countries. These indicators are viewed as more objective than qualitative indicators, as they are less influenced by interpretations and more evidence-based. Qualitative indicators, on the other hand, create data based on questions that form a narrative that can then be used for measurement purposes. These data points can be used to elaborate upon quantitative measurements in order to give a more comprehensive look into the state of human rights-related affairs in a region (OHCHR, 2012).

Similarly, HRIs can also be fact- or judgment-based. Fact-based indicators refer to concrete, objective evidence, while judgment-based indicators refer to subjective information often presented in the form of opinions or perceptions. While qualitative and judgment-based indicators can more completely depict a given situation, policy makers and governments have preferred the use of quantitative and fact-based indicators to measure human rights statuses because they are often easier to interpret, more easily compared

across borders, and generally more verifiable. Of course, these indicators do have limitations in that they can oversimplify complex issues. For this reason, qualitative and judgment-based indicators are often used to supplement the information provided by the numerical and objective indicators (OHCHR, 2012).

Other, less common HRI types are characterized by performance or compliance. Performance indicators allow for organizations or donors looking to fund human rights-specific initiatives to verify whether an existing intervention or policy is effecting the change intended. They are less frequently utilized because they are often created to measure only a specific initiative. Thus, they do not provide the broad outlook generally necessary to analyzing human rights conditions. Compliance indicators are similar in that they are meant to evaluate progress being made toward a certain goal; however, they differ in that they are specific to the standards of human rights. Compliance indicators measure the extent to which a country or organization is meeting the human rights regulations set in place within that region. These indicators intend to monitor duty bearers and evaluate the degree to which they are addressing their communities' present issues. More simply put, compliance indicators pinpoint where duty bearers are falling short of their duties and not complying with human rights standards; they can thus be used to ensure accountability (OHCHR, 2012).

In general, the OHCHR encourages the use of quantitative and fact-based measurements over qualitative, opinion-based, performance, and compliance indicators. Quantitative and fact-based indicators are preferred in the HRI process, for they are considered the best choice to facilitate human rights data aggregation and comparisons across governments and policy makers (OHCHR, 2012).

Second Objective: Attribute Selection

The OHCHR recommends that each right be disaggregated into four or five attributes in order to best assign indicators for measurement (McGrogan, 2016). According to the OHCHR, the right to life, for example, can be broken down into the attributes of 'arbitrary deprivation of life,' 'disappearances of individuals,' 'health and nutrition' and 'death penalty.' Selecting attributes to characterize each right reflects duty bearers' obligations to the three pillars of HRIs regarding respecting, protecting, and fulfilling all

human rights; acknowledges and reflects the interconnectedness of human rights norms; establishes equal footing for all human rights; assists relevant treaty bodies in the assessment of compliance with human rights standards; and facilitates the selection of contextually meaningful indicators in the next stage of the process (OHCHR, 2012).

The second objective of the HRIs is to explicitly link a given right with a complementary indicator, a step that essentially requires attaching a normative standard to a corresponding measurement. This stage streamlines the various rights into easily identifiable properties that allow a relatively quick and simple indicator selection process (McGrogan, 2016). Next, each attribute must be linked to its complementary indicator, which provides an evidence-based analysis for the right itself. Each human right can also be broken down into concise attributes and assigned indicators to measure the degree to which the human right is being fulfilled by the state actors.

Third Objective: Structure-Process-Outcome Model

After the attributes are selected, a consistent approach to selecting and developing indicators must be followed. A framework that guides this step is Avedis Donabedian's model of structure-process-outcome, a model originally intended to assess the quality of services provided in the healthcare industry. According to this model, each right must be assigned a set of structure, process and outcome indicators which would, in turn, be used to evaluate a country's commitment to protecting human rights and assess their efforts and results (McGrogan, 2016). This stage must address the importance of quantifying human rights outcomes, as well as the processes that underly them (OHCHR, 2012).

These types of indicators serve specific and distinct purposes. For instance, structural indicators help to assess implementing standards; process indicators measure the degree to which a duty bearer has transformed human rights commitment efforts into results and achievements; and outcome indicators contextually reflect these human rights achievements, or highlight the lack thereof. Context-specific indicators are key to monitoring human rights, as they demonstrate the importance of explicit and clear definitions to the HRI process (OHCHR, 2012).

3.2 - Limitations to the HRIs

Given the relatively novel proclivity of national and international stakeholders to use indicators to measure human rights, the methodology behind indicators, specifically with regard to human rights, has its challenges and tradeoffs. The fact that indicators rely on the measurement of a total aggregate, while human rights are particular to an individual, is of major concern and foundational to HRIs – what makes human rights essentially human rights (Merry, 2011). Further, in order to best understand the benefits that indicators bring to the field of human rights and measurement procedures in general, we must first consider the ethical and logistical challenges to creating and implementing indicators.

HRIs face inherent shortcomings in their assessment capabilities, for they act as an instrument that is paradoxically intended to both simplify and at the same time comprehensively portray the complexity of human rights by means of standardized measurement. One major concern regarding the use of any indicator, especially pertinent to the use of HRIs, is that the quality and quantity of data varies extensively across countries, greatly affecting the quality and degree of comparisons. A lack of cross-border comparison resulting from inadequate data collection limits the abilities of international institutions and civil society organizations to make well-informed and evidence-based recommendations and protocol decisions regarding human rights concerns. Insufficient data can also limit the tracking ability of government officials within a country, as the variety of information gathered may be too vast and disparate to allow for fruitful comparison (OHCHR, 2012).

Logistically, encouraging countries to improve upon their data collection methods while simultaneously urging them to increase the amount of data that is collected is an issue central to the mainstreaming of indicators. This concern is two-fold in that data collection requires financial backing as well as political backing. Implementing and using HRIs requires staffing, infield data collection training, and digital tools like computers and large data storage capabilities to record the information. Even countries with the necessary budget must also choose to allot funds in this specific way, requiring additional support from political actors. Furthermore, in the case of countries that lack sufficient funds, those countries must either reallocate their budgets to finance the HRIs or continue data collection as normal without implementing these new methods.

The financial capability of a country is, however, only one factor in the process toward implementing HRIs, as a country's government must also be motivated to finance the implementation. Motivation can stem from either a government's sheer inclination to improve human rights conditions and enact positive change for its citizens; or, as is more commonly the case, from the fear that other countries may hold them accountable if poor human rights conditions continue as a result of noncompliance with new standards.

Such peer accountability can be used as a means to incentivize participation. An example of a repercussion that might influence a country to join a human rights initiative is the threat of sanctions. Sanctions, or the blocking of trade by a country, person or entity, are often used by governments to demonstrate disagreement with the political, social, or economic practices of a particular region. To avert abuse of this possibility, the European Union adopted the EU Global Human Rights Sanctions Regime in 2020 to "more forcefully stand up for human rights." This sanctioning tool is novel in that it allows the EU to specifically target human rights abusers and corporate violators without necessarily placing blame on the entire country – in the case that the entire country is not to blame. The EU claims that it "uses sanctions as a political tool aimed at policies or activities that [it] wants to influence" (European Union, 2020, "Why was the EU").

Once economic and political backing is secured to implement HRIs in a country, the next step is to ensure that the data collection process includes the ability to effectively disseminate the garnered information to the relevant bodies. This is crucial, for these compiled statistics are essentially meaningless if the necessary actors cannot access them. If the dissemination stage is established, human rights stakeholders can incorporate these figures to adjust existing policies and execute new policies with the potential to increase citizens' wellbeing.

While disaggregating the data is thus essential to supporting human rights endeavors, it presents additional challenges. Not only do logistical concerns arise regarding the ability of statistical offices to disseminate information to the necessary actors, but ethical concerns related to distribution also arise. For example, the collected data often includes personal and private details of vulnerable populations, and compiling such data sets requires measuring characteristics that may be considered controversial by societies,

shameful by individuals, or even illegal by governments. Thus, using HRIs to measure human rights-related conditions is a delicate topic that requires strict adherence to protections of privacy, assurances of anonymity and culturally sensitive methods of data sampling (OHCHR, 2012).

Aside from fear of embarrassment, there are other considerations regarding the data collection process and its effects on certain populations. Even the preliminary act of identifying certain demographics in the HRI process may lead to discriminatory behavior or punishments from societal and political actors. For instance, if privacy and anonymity are not maintained when identifying transgender individuals or discussing reproductive and sexual health with women in a particular region, those individuals may face grave consequences including punishment in the form of societal ostracism, lengthy jail time, or even death. Culturally sensitive subject matters may cause ethical concern, as well, depending on the existing cultural and religious practices and attitudes within a region. In cases like this, indicators and data sampling methods may require adjustment in order to respect these circumstances (OHCHR, 2012). Hence, ensuring the right to privacy, maintaining culturally sensitive data collection methods, and establishing secure data aggregation practices are all absolutely crucial steps to successful HRI implementation and usage.

Next, evidence of 'gaming' indicators must be explored, as it seems not everyone is motivated to do good solely for the sake of protecting human rights. In the past, in order to score better on the human rights 'index,' countries and corporations have schemed to manipulate what is counted by an indicator. Such manipulation raises HRI scores while bringing about little to no change of the actual human rights standard. As a parallel example, some universities in the US that initially scored low by the *US News and World Report* for levels of alumni giving have taken to encouraging their donors to divide their gifts into three payments – increasing their raw score in this category yet not actually increasing the dollar amount received. The indicator seemingly indicated increased alumni engagement even though no such improvement occurred (Merry, 2011). By virtue of this, when looking at scores and rankings across countries, it is important to remember that the indicator being utilized may mask outside influences that are not directly concerned with

bettering human rights conditions. This possibility demonstrates that indicators can simultaneously be oversimplified and conceal complex motives of governments and policy makers – a paradoxical challenge to HRI usage.

Another criticism of HRIs is that they focus too specifically on measuring outcome-specific factors at the expense of identifying the root causes of human rights infringements. This concern is exacerbated by the fact that it is often too difficult or insufficient to quantify the subjective character of human rights, which potentially may not be numerically or categorically broken down in such a way. However, while these concerns are valid, they, in fact, overlook the true nature of HRIs. When creating the HRIs, the OHCHR claims that it did not intend for them to be used at the cost of other instruments of measurement. Instead, the OHCHR maintains that the HRIs were created to facilitate international bodies, governments, and civil society organizations in their assessment of human rights conditions, and to improve their overall understanding by giving a step-by-step guide to accurately measuring these conditions, which in turn demonstrates their scope and magnitude. Hence, when assessing the effectiveness of the HRIs, it is important to remember that they were not constructed as an 'all-inclusive' method of measurement, as many critics claim (OHCHR, 2012).

3.3 – Positive Features of the HRIs

Given the challenges associated with the use of indicators as proxies for complex issues like human rights, coupled with the logistical concerns regarding physical implementation, it is evident that numerous and varied complications exist that can potentially derail HRI implementation. However, HRIs and indicators in general do possess redeeming qualities that have led many human rights activists and a majority of international bodies to conclude that the pros outweigh the cons. These attributes, therefore, must also be considered in this HRI analysis.

According to J.K. Galbraith, a prominent economist, diplomat, and policy maker, "if it is not counted, it tends not to be noticed" (OHCHR, 2012, p.1). This statement suggests that measurements are needed to identify what is working and what is falling short in a given situation. Measurements can shed light on human rights conditions, and can ultimately effect appropriate change and improve quality of life within a region. Indicators

can also be used as evidence to back decisions, and more importantly, to measure progress towards fulfillment of human rights. Indicators provide a heightened degree of certainty, clarity, and impartiality in important decisions. This objectivity increasingly appeals to numerous stakeholders, just as donors and governments have preferred an evidence-based approach as the standard methodological practice in measuring human rights. These actors rely on evidence provided by indicators to allocate funding for specific initiatives and regions, effectively impacting policies that may improve human rights standards (OHCHR, 2012).

What distinguishes a number from an indicator is crucial to assessing the effectiveness of indicators. While numbers serve as quantification conduits, indicators are policy instruments that consolidate complex data and statistics into more meaningful groups for use by governments and policymakers. While numbers are simple, indicators are complex, as the bedrock of indicators lies in the choice of how data is grouped and labeled. Numbers may be "value-free descriptions;" however, indicators incorporate political and corporate motives – often subconsciously – into their foundation (Merry, 2011). Indicators simplify complex issues of governance into meaningful constructs that signifies much more than what is quantified. By virtue of this, the use of indicators requires comprehensive knowledge of what is being counted, why it's being counted, and who is asking for the count. With this knowledge, HRIs can strengthen human rights practices around the globe.

The capability of HRIs to effectively describe, document, classify, categorize, and monitor human rights practices allows international actors to efficiently and effectively evaluate and map compliance with human rights standards. HRIs' streamlined and systematic process is an advantage that more judgement-based measurement methods do not possess. Its methodical and structured assessment method enables quicker change at the governmental level, as officials will have more readily available access to more reliable data (McGrogan, 2016). Further, HRIs offer a consistent means of measurement applicable to a variety of situations and uses. While measurement tools like expert opinions might include subtle or more apparent biases, HRIs offer an accurate and rational evaluation tool that better mitigates concerns of partiality.

Another positive quality of HRIs is that they are extremely purposive and link the conceptualization of human rights with the implementation of human rights practices. They both measure human rights, and "instigate movement in pre-determined directions and supply ready-made policy goals" (McGrogan, 2016, p. 395). This quality allows government officials and policy makers to translate collected data in an action-oriented way. HRIs are thus not merely tools to assess human rights compliance, as they can also transform targets and benchmarks into policy and actual improvement in human rights – HRIs' ultimate goal.

The development of universal HRIs also reinforces the ideal that human rights are, in fact, universal and inalienable, no matter one's location around the globe. By creating a blanket set of indicators for implementation and use throughout all regions, the HRIs affirm that international human rights law should similarly be universally recognized and ultimately standardized to foster compliance (McGrogan, 2016).

Thus, stakeholders must work to mitigate concerns regarding HRIs in order to reap their benefits, as HRIs are essential to human rights and human rights' highest fulfillment.

Chapter 4 – Applying a Human Rights-Based Approach to Maternal Health

4.1 - Maternal Health

To demonstrate the applicability of HRIs to a singular, specialized setting, the following sections will focus specifically on human rights conditions that are linked to maternal health. This focus is rooted in the fact that governments have legal obligations under international human rights law to ensure the highest attainment possible for maternal health standards, and maternal health conditions often reflect the broader state of human rights practices within a region (OHCHR, n.d.-a). Thus, discussing maternal health's relation to human rights, and the use of HRIs to measure maternal health conditions, provides an interesting basis to analyze the overall effectiveness of HRIs.

According to the World Health Organization (WHO), many societies actively devalue women in favor of men, an attitude symbolic of the perceived duties of the sexes within a culture or region. This lower societal status can often result in discriminatory behavior against women, including the denial of certain human rights. Since international human rights laws guarantee equity in rights regardless of one's sex, many of these disadvantages women face, including a lack of quality maternal healthcare, are linked to human rights injustices. Women's maternal health rights can be violated in many ways, including lack of access to health services, and lack of information concerning health options. These structural impediments are exacerbated by socioeconomic factors that influence a woman's quality of life, such as where she works, how much money she makes, and her level of familial support (Cook, 1994). Evaluating maternal health is thus essential for governments and organizations to better understand the state of human rights standards in a region.

To begin, pertinent terms must be defined to best facilitate this discussion. Maternal health and the terms associated with it will be considered in depth, as these determinants both directly and indirectly link to the overall state of human rights in a region.

The WHO describes maternal health as the health of a woman during pregnancy, childbirth and the one year following the end of pregnancy, commonly referred to as the postnatal or antenatal period (World Health Organization, n.d.). The World Bank estimates that 49.7% of the world's population today is female and that the global average of births a

woman experiences in her lifetime is 2.3 (World Bank, 2022). Given that a typical pregnancy lasts nine months, just short of half of the global population will generally spend close to three years of life pregnant. Maternal health is thus a global issue affecting all populations regardless of nationality, religion, and socioeconomic status.

Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (Rodriguez et al., 2014, p. 3). While similar in nature, reproductive health and maternal health have key differences. Reproductive health refers to the quality of health for the entire reproductive system, and maternal health more specifically refers to the quality of health for a female who is actively pregnant or recently has given birth (Rodriguez et al., 2014**)**. By virtue of this, reproductive health is a foundational element to maternal health and the two concepts are intrinsically linked. Maternal health thus encompasses a multitude of factors that all must be addressed to ensure the overall well-being of a woman, factors that are directly dependent on the state of human rights conditions in a region and on the human rights assurances provided by the state and its healthcare systems.

Maternal mortality and maternal morbidity rates are two essential elements to maternal health. According to the National Institute of Health (NIH), maternal mortality refers to the death of a woman that occurs either during pregnancy or within one year following the end of her pregnancy as a direct result of or aggravated by the pregnancy or act of giving birth itself. Similarly, maternal morbidity, according to the WHO, constitutes any health condition that can be attributed to or exacerbated by pregnancy and childbirth and has negative consequences on a woman's overall wellbeing, but does not result in death (U.S. Department of Health, n.d.). Some of the most common causes of maternal mortality and morbidity are "excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anemia, malaria, and heart disease" (World Health Organization, n.d., "Maternal health").

Maternal mortality and maternal morbidity rates can be used as proxies for understanding human rights conditions relating to maternal health, and to measure the extent of national health and well-being (Crear-Perry et al., 2021). To illustrate their

importance, the OHCHR has described heightened levels of maternal mortality and morbidity as reflective of inequality and discrimination experienced by women, due to and exacerbated by formal laws and regulations, as well as social norms and practices within a region (OHCHR, n.d.-c). Conversely, low rates of maternal mortality and maternal morbidity correlate with positive human rights conditions, as well as low levels of human rights violations.

4.2 - Underlying Determinants of Maternal Health

While maternal health is directly influenced by the level of health a woman is able to maintain from conception to one year post-childbirth, additional underlying factors can also affect her enjoyment of health during this time. Factors that define conditions in which people are born, grow, live, work, and age, factors that the WHO describes as social or structural determinants of health, all have the ability to influence a woman's quality of health during maternity (Crear-Perry et al., 2021). While the right to health directly incorporates the values of "availability, accessibility, acceptability and quality of services (commonly referred to as AAAQ)," it also incorporates many socioeconomic determinants of health that can indirectly affect the quality of a person's life. These socioeconomic factors include everything from access to food, water and adequate housing, to acceptable sanitation practices and safe working conditions. These factors are in and of themselves human rights (Rodriguez et al., 2014, pp. 4-6).

These social determinants of health are causally related to human rights and the right to health, as inequities stemming from systemic discriminatory practices affect a person's ability to live her life. The degree to which these prejudices exist influences the level of quality living a person can attain (Kenyon et al., 2018). In the realm of maternal health, inequities subtly present themselves in many ways including cultural insensitivity toward minority patients by medical personnel, lack of adequate sexual education provided by public schools for adolescents due to insufficient government funding, and poorer quality of health services resulting from ethnic and racial discrimination by practitioners. These inequities are numerous and pervasive. Ensuring access to and availability of quality maternal healthcare for all women, regardless of ethnicity, race, age, or other personal characteristics, is thus essential to ensuring the well-being of both mother and child, as poor

maternal health can have lasting consequences on future generations, and negatively impact society as a whole. Therefore, evaluating maternal health conditions can serve as an important indicator of the overall state of human rights within a region, for maternal health is a multi-faceted issue with many intersectionalities across other areas of human rights.

Chapter 5 - Human Rights and Maternal Health

5.1 – Human Rights Linked to Maternal Health

According to the OHCHR, "reducing maternal mortality and morbidity is not solely an issue of development, but a matter of human rights." To facilitate the process of addressing maternal health through a human rights-based approach, the UN's Human Rights Council (HRC) has identified a variety of human rights that correlate with rates of maternal mortality and morbidity within a region. These rights include the "rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health" (OHCHR, n.d.-c, p. 3).

In a concerted effort to achieve equity in health, the WHO also officially recognized the importance of human rights in health by including and adopting the right to health in its constitution in 1946. Since then, certain health-related rights have been incorporated into many human rights treaties including the ICESCR, a covenant of the International Bill of Human Rights previously mentioned. Similarly, the right to health discussion has gained momentum at international conventions. Evidently, governmental actors and stakeholders at the national and international levels increasingly understand that addressing maternal health is essential to ensuring the highest degree of human rights fulfillment for societies (OHCHR, n.d.-b).

With specific regard to maternal health-related human rights, the UN Secretary-General's Global Strategy on Women's and Children's Health and the Commission on Information and Accountability for Women's and Children's Health have officially acknowledged that ensuring and strengthening the extent of accountability is a crucial, often overlooked, first step in the quest to better both women and children's health, equal in importance to reducing maternal mortality and morbidity rates. The Secretary General has further emphasized the need to formally link this accountability regarding access to and quality of maternal healthcare, to that of human rights and human rights protections, because merely acknowledging a correlation between the two is not enough. Ensuring accountability in the realm of health-related and maternal health-related human rights is

foundational to guaranteeing the rights to health, equity in health, and gender equality in health (Bueno de Mesquita & Kismödi, 2012).

5.2 – HRIs for Maternal Health Monitoring

Given the complexity and wide variation of factors relating to the right to health, effective monitoring instruments are needed to ensure accountability in this realm. These monitoring instruments must be able to evaluate the structural factors that govern health systems, health providers, and the underlying social determinants of health; they must be able to process capacities and characteristics within these three areas; and they must be able to analyze the extent and magnitude of health-related human rights outcomes that result from these elements, both directly and indirectly. Further, in order to ensure that a human rights-based approach to evaluating health conditions is maintained throughout the monitoring process, both quantitative and qualitative indicators must be utilized.

While the *Human Rights Indicators* proposed by the OHCHR acknowledge a preference towards quantitative indicators over qualitative measurements due to their objective and fact-based nature, indicators that effectively monitor qualitative characteristics must also be developed for inclusion in adjustments to existing methodology, as well as in new approaches. This way, a more detailed and comprehensive picture of the state of health-related human rights attainment in a region can be provided to the relevant actors and policy makers. Examples of ways to do this are improving data disaggregation methods and increasing the amount of health-specific data that is disaggregated. The WHO suggests that these methods may facilitate the development of qualitative indicators, as well as optimize existing quantitative measurements. Specifically, the WHO believes that "a comprehensive approach to monitoring rights will require identifying and developing qualitative and policy indicators, as well as new quantitative indicators" (Rodriguez et al., 2014, p. 1).

By ensuring that data is adequately managed, analysts and officials will have an appropriate understanding of the state of human rights conditions in a region. They can use that information to select which health-related human rights problems to focus on, as the data will evidence which rights are being directly and/or indirectly violated within that region. The basis for disaggregating health-related human rights information should include

specific information regarding age, geographic area, description of the administrative style used in the region, as well as any other pertinent characteristics that may affect health-related human rights (Rodriguez et al., 2014). For instance, hospitals should have the ability to collect and provide patient-specific data, maintaining record of each patient's age, sex, occupation, previous health challenges, and current health complaint. For women of reproductive age, the information collected could additionally include elements such as number of pregnancies, number of children, type of contraceptive(s) used, amount of alcohol consumption, and marital status. For even more detailed records, information could also include age of first intercourse, menstrual cycle information, preferred birthing style and use of midwifery care, as well as the patient's/guardians' income and level of educational attainment. The more details that are recorded, the more information that policy makers and relevant actors can access. This data can subsequently be used to evaluate the state of human rights in a region through the lens of health-related and maternal health-related care.

5.3 – Human Rights and Associated Maternal Health Conditions

While it appears that maternal health practices and health-related rights are garnering increased focus from international bodies, quality data and research, as well as implementation of accurate indicators for measuring national and international maternal health quality, are crucial to bringing about necessary changes in this field. To date, the WHO has identified 121 health conditions that are linked to maternal health, and that it believes may exacerbate or even directly cause injuries and death for pregnant or recently pregnant women. Four baseline concerns demonstrate the dangers a woman may face during maternity: 1) obstetric-related complications resulting from unsafe abortion practices; 2) hypertension; 3) prolonged or obstructed labor; and 4) obstetric hemorrhaging. These four conditions, as well as the other 117 conditions recognized by the WHO, can lead to detrimental injuries for both women and the children being birthed, and may even lead to death for one or more parties (United Nations, 2020).

While pregnancy and childbirth naturally put a dangerous level of strain on a woman's body and can result in injury and even death for both mother and child, the majority of complications women face today are largely considered preventable (OHCHR,

n.d.-a). The fact that despite preventability, the rates of maternal mortality and morbidity throughout the world remain high, highlights the inequity and discrimination women face as a result of inadequate healthcare, lack of access to health-systems and health-related technologies, and underlying socioeconomic factors. These rates reflect human rights conditions within society, and ultimately demonstrate that maternity renders women more vulnerable to prejudices and increases their susceptibility to human rights violations. Addressing the circumstances that lead to these conditions and ensuring adequate health protection for pregnant women and mothers is thus critical to guaranteeing the enjoyment of human rights for this especially vulnerable demographic. In turn, regulations concerning maternal health and accountability when wrongdoing occurs are also essential to lowering morbidity and mortality rates. In sum, to ensure that maternal health-related rights are "premised upon empowering women to claim their rights, and not merely avoiding maternal death or morbidity," depends on ensuring accountability, participation, transparency, empowerment, sustainability and non-discrimination (OHCHR, 2020, p. 2).

5.4 - Challenges to Using HRIs to Monitor Maternal Health

Generally speaking, indicators provide valuable insights into the field of health care; however, there is evidence that many health systems do not utilize HRIs to their fullest extent as initially conceptualized by the OHCHR. One reason for this stems from the limitations presented by HRIs' three objectives when measuring health-related human rights practices. The complexities of the health sector and its influence on the success of societies and wellbeing of citizens highlight the importance of developing monitoring systems that ensure transparency and accountability. These complexities, however, make it extremely difficult to develop sweeping indicators even when following the OHCHR's *Human Rights Indicators* and even when acknowledging the growing international commitment to human rights-based health programs. The WHO, although recognizing that HRIs have been utilized in some health-related cases, nonetheless holds that "a systematic, transparent system does not yet exist that explicitly links human rights and health concerns, and then determines their combined impact on the effectiveness and outcomes of health policies and programmes" (Rodriguez et al., 2014, pp. 1-5). HRIs can provide meaningful data regarding certain health outcomes, but seem to have a limiting feature, as they are not

specific to health-related and maternal health-related rights. This assessment of the state of HRI use in health-related fields thus reveals some of the limitations of the OHCHR's *Human Rights Indicators*, as it is not precise enough to be effectively used in the health and public health sectors.

While HRIs encourage the use of quantitative measurements over qualitative, as emphasized by their first objective, gaps in data produced by this method are apparent and may lead to inaccurate results. To demonstrate such a gap, the WHO convened an Indicator Advisory Group (IAG) consisting of experts in the fields of both human rights and indicator methodology, to assess the validation of existing indicators and their level of effective measurement of human rights-related health conditions. The IAG considered over 40 indicators as having either a direct or indirect connection to the right to health, and created a list of questions to pinpoint the degree to which an indicator accurately measures the health condition it was intended to evaluate. The questionnaire methodology that the IAG implemented aimed to evaluate 1) the extent of explicity between the right and the indicator; 2) the implicity between the two; 3) the human rights principles associated with each indicator; 4) the existing degree of legal protection ensured against the human rights violation being measured; and 5) the ability of the indicator combined with other indicators to provide a more comprehensive description of human rights standards. This process narrowed the 40 indicators down to 12. The IAG then set forth to utilize these indicators in final assessments determining the correlation between health and the availability, accessibility, etc. of certain programs. The study recognized that the list of indicators lacked important details regarding health conditions and did not accurately portray the full picture. None of the indicators were qualitative in nature; none were able to measure individual agency in healthcare; and none measured quality of care received (Rodriguez et al., 2014).

When measuring contraceptive prevalence rate and contraceptive types utilized, for instance, the WHO concluded that the indicators do not account for the quality of the information collected, as they left out important factors including the "safety and reliability of contraceptive services…[and] the availability of counseling and support for marginalized groups, including…indigenous people, ethnic minorities…and transgender…people" (Rodriguez et al., 2014, p. 26). Thus, quantitative indicators can lack the ability to

comprehensively analyze maternal health-related human rights conditions, which perhaps may be better assessed through qualitative indicators.

As discussed with regard to the second HRI objective, attributes and indicators must be assigned to each right in order to facilitate the monitoring process and aid in the realization of human rights advocacy. According to the *Human Rights Indicators*, attributes that can be assigned to the right to health – a cornerstone right in maternal health rights protection and attainment – are 1) child mortality and healthcare; 2) sexual and reproductive health; 3) natural and occupational environmental conditions; 4) prevention; 5) treatment and control of diseases; and 6) accessibility to health facilities and essential medicine. These attributes are based on article 25 of the UDHR, article 12 of the ICESCR, general comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights, general recommendation No. 24 (1999) of the Committee on the Elimination of Discrimination against Women, central comments Nos. 3 (2003) and 4 (2003) of the committee on the Rights of the Child, as well as indirectly based on many other articles and comments (see: *Figure I*) (OHCHR, 2012).

Identifying attributes and selecting indicators to measure the right to health illuminates the intersectionality of human rights and human rights treaty bodies, as well as the need to evaluate rights through an interdisciplinary approach. This multidimensional assignment of attributes ensures that rights can be comprehensively assessed, mitigating concerns of oversimplification and narration generally attributed to HRIs. At the same time, the assignment of attributes may not always be rooted in scientific fact, as the selection process is more subjective in nature. While one group may select attributes at the hospital level, other groups may prefer attributes specific to individuals. Similarly, certain attributes may be more appropriate for lower-income rather than higher-income countries. Differences in attribute selection can thus lead to a variety of results produced by the HRIs (Saturno-Hernández et al., 2019).

To address the third objective of HRIs, creating indicators for maternal health must follow a structure-process-outcome model. The Agency for Healthcare Research and Quality provides examples of structural-, process-, and outcome-related indicators that can be used to evaluate health care quality and the use of HRIs to ensure the right to health. For

structural measures, the Agency suggests evaluating the ratio of board-certified physicians to patients, as well as the ratio of other medical providers to patients; recommends process indicators that include assessing the percentage of people who have received or are receiving preventive services; and proposes that outcome measures include looking at the percentage of mortalities caused by health services received in the hospital and the number of hospital-acquired infections ("Types of health care quality," 2015).

These example indicators proposed by the Agency, while linked to general health services in this case, are also extremely pertinent in the assessment process for maternal healthcare in a hospital setting. More specifically, in rural areas throughout the US, many hospitals do not provide OBGYN care for women (Rabin, 2023b). To evaluate this scenario using HRIs, a structural indicator evaluating the proportion of board-certified physicians would produce a low or even nonexistent result, depending on the situation; process indicators assessing the number of people seeking OBGYN care and the number of people receiving OBGYN care could produce a high and low score, respectively; and an outcome indicator measuring the percentage of mortalities due to healthcare received at a hospital may result in a varied score, since a low amount of care provided would necessarily result in a low number of mortalities. These indicators provide insight into the state of human rights vis à vis availability of and access to healthcare, as availability of and access to healthcare are necessary to ensure the right to life and the avoidance of preventable diseases or death during maternity.

While health systems have utilized structure and process indicators, outcome indicators have seemed to take less priority, for they can often be too expensive to measure and too unmanageable for data collection. A study conducted by Salampessy et al. set out to determine the usefulness of structure, process, and outcome indicators by assessing the degree of correlation between the three insofar as they aim to measure public healthcare conditions at the hospital level. The report found that structure and process indicators actually shared little to no correlation with outcome indicators and concluded that structure and process indicators were only adequate to measure internal conditions to be used by hospital management, and were considered 'unsuitable' proxies for informing the public

about differences in health outcomes across hospitals; ironically, their intended purpose (Salempessy et al., 2021).

Given these findings, a gap seems to exist between the measurements provided and the usefulness of those measurements. This gap may indicate that 1) structure and process indicators cannot be relied on to serve as signals for informing the public on differences in health outcomes; 2) they may be unreliable sources of evidence for human rights conditions within a region; and/or 3) a disconnect exists somewhere else in the process.

While the indicators were not reliable to determine these outcome differences, they may still be utilized by internal management in order to assess quality of care. Health systems must therefore strive to use indicators appropriately as they are not sufficient in all scenarios (Salempessy et al., 2021). These findings, while specific to the situation concerning health outcome differences between hospitals, may suggest that the structure, process, and outcome indicators suggested by the *Human Rights Indicators* evaluate some human rights standards better than others. Similarly, the study demonstrates one reason why health organizations may prefer other measuring methodologies over HRIs.

As of March 2023, the current global average for maternal mortality rates stands at 223 deaths per 100,000 live births, and for countries facing humanitarian crises, that rate jumps to 551 deaths per 100,000 live births. While the WHO considers the issue of maternal mortality a priority and has set a goal to cut maternal mortality rates to 70 deaths per 100,000 live births by 2030, these numbers demonstrate the magnitude of the maternal health crisis plaguing the world today. With only seven years to hit this maternal mortality reduction target, this goal may seem lofty; however, progress in this area is possible. For example, the WHO cites evidence that 75 countries were able to reduce their maternal mortality rates by half or more between 2000 and 2015, after the Millennium Development Goals initiated in 2000 encouraged countries to address issues of health and maternal health. Unfortunately, that rate of reduction has significantly stalled throughout the world as people and their governing bodies have had to endure the unprecedented Covid-19 pandemic, which placed and continues to place an extraordinary strain on financial as well as health-related resources (Rabin, 2023a).

Chapter 6 – Case Study: Using HRIs to Assess Maternal Health Conditions

6.1 – Using HRIs to Assess Maternal Health in the US and the Netherlands

To better understand how a health or public health institution may utilize the HRI framework, the following chapter will work through the aforementioned process and specifically tailor the selection of indicators toward measuring maternal health, and not just the standard of health in general. Once the relevant HRIs have been selected, they will be applied to a case study comparing the quality of maternal health in the US and the Netherlands.

By analyzing the quality of maternal health in the US and the Netherlands, this comparison will demonstrate that maternal health standards do not solely depend on a country's level of development, but instead are intrinsically linked to that country's human rights practices and the priority it gives to addressing human rights violations. Although these two countries share many socioeconomic characteristics, the main two being that 1) they are both considered developed countries with relatively standardized legal practices; and 2) their governmental leaders and corporate officials seem to understand and value respect for human rights within their regions, the general state of maternal health between the US and the Netherlands differs substantially. The US, on one hand, has the highest maternal mortality rate of any developed country – higher than that of some developing countries – while the Netherlands has one of the lowest rates (Tikkanen et al., 2020). It is thus crucial to understand the cause of such differences in maternal healthcare practices, the variations in underlying social determinants of health, and the contrasting prioritization of maternal health and health as a human right.

This chapter further relates maternal health to the specific discourse regarding the usefulness of HRIs by following the methods encouraged by the OHCHR and the three objectives of indicator selection – quantitative measurements, attribute selection, and the structure-process-outcome model. This comparison will allow deeper understanding of whether HRIs are sufficiently functional in the healthcare sector, or if existing limitations hinder their applicability.

6.2 - Selection of HRIs for Case Study

First, while maternal health relates to many human rights including the rights to life, health, equity and equality, and non-discrimination, this analysis will only assess the right to health. It is therefore necessary to keep in mind that the results discussed below will not completely account for the full extent of measurement methods involved in maternal health.

Next, to accurately follow the process of HRI selection, the three objectives of HRIs must be accounted for: a quantitative base, attribute selection, and the structure-process-outcome model. Identifying the normative framework for the right to health is necessary to select the best attributes. This selection process requires an exhaustive understanding of the legal standard of the right to health. Attributes selected must also be mutually exclusive in nature in order to avoid overlapping that may result in double counting of data. Each attribute selected must then be assigned structure, process, and outcome indicators. The structure, process, and outcome indicators used should display a linkage or causality between them that, when considered together, will best capture the essence of the right. In the case of the right to health, however, certain outcome indicators may lack a direct link to structure and process indicators, since they may more strongly correlate with lifestyle choices or other underlying determinants. The preferred indicators will also be quantifiable in order to best facilitate data aggregation and comparisons used by governments and policy makers to address human rights standards (see: *Figure II*) (OHCHR, 2012).

The *Human Rights Indicators* framework lays out potential attributes that may be linked to the right to health; however, in order to best understand the specificities of maternal health standards, they have been slightly adjusted for this report (see: *Figure III*). The attributes selected for the right to health specifically tailored for maternal health are 1) sexual and reproductive health; 2) maternal mortality and health care; 3) prevention, treatment, and control of diseases; and 4) accessibility to health facilities and essential medicines.

Now that the attributes have been identified, the proper structure-process-outcome indicators must be selected. For a comprehensive analysis, multiple structure, process, and outcome indicators should be utilized; however, this report will only focus on one indicator from each category.

HRIs - Illustration of Selection Process Pertaining to the Right to Health* Specified for Maternal Health Conditions				
	Attributes selected for Right to Health (Specific to Maternal Health)			
Indicators for Structure-Process-Outcome Model	**Sexual & Reproductive Health**	**Maternal Mortality & Healthcare**	**Prevention, Treatment, & Control of Diseases**	**Accessibility to Health Facilities & Essential Medicines**
Structure	Time frame and coverage of national policy on abortion	Coverage of national policy on maternal health	Coverage of domestic laws for implementing the right to health	Estimated proportion of births recorded through vital registration systems
Process	Proportion of births attended by skilled personnel	Proportion of females of adolescent age educated on sexual, reproductive or maternal health issues in a traditional school setting	Proportion of pregnant women immunized against Tdap	Density of physicians
Outcome	Contraceptive prevalence	Maternal mortality rate	Life expectancy at birth	Proportion of births in a hospital setting
**Right to health is shortened to represent the right to the enjoyment of the highest attainable standard of physical and mental health [Universal Declaration of Human Rights, art. 25]*				

*Tables are created solely for the purposes of this report by author

Key for HRI Table:	Objective #1 Quantitative Nature (*YELLOW*)	Objective #2 Attribute Linked to Right (*PINK*)	Objective #3 Structure-Process-Outcome Model (*BLUE*)

HRIs - United States				
	Sexual & Reproductive Health	**Maternal Mortality & Healthcare**	**Prevention, Treatment, & Control of Diseases**	**Accessibility to Health Facilities & Essential Medicines**
Structure	Time frame and coverage of national policy on abortion: (2022) right to abortion revoked by US government [Coen-Sanchez et al., 2022]	Coverage of national policy on maternal health: (2022) Maternal Health Blueprint released by US government [Bryant, 2023]	Coverage of domestic laws for implementing the right to health: Article 36(3) of US Constitution stipulates protections to health [Jung, 2020]	Estimated proportion of births recorded through vital registration systems: (2021) ~100% recorded [UNICEF Data, n.d.-b]
Process	Proportion of births attended by skilled personnel: (2019) ~99% attended [UNICEF & World Bank, n.d.-b]	Proportion of females of adolescent age educated on sexual, reproductive or maternal health issues in a traditional school setting: (2010) ~96% educated on issue [Tyler et al., 2014]	Proportion of pregnant women immunized against Tdap: (2021) ~44% of pregnant women immunized [CDC, 2022]	Density of physicians: (2018) ~2.6 physicians per 1,000 residents [World Health Organization's Global, n.d.-b]
Outcome	Contraceptive prevalence: (2018) ~74% of married women ages 15-49 used [Household surveys & World Bank, n.d.-b]	Maternal mortality rate: (2021) ~21 deaths per 100,000 births [WHO et al., n.d.-b]	Life expectancy at birth: (2021) 76 years [United Nations Population, 2022b]	Proportion of births in a hospital setting: (2019) 98.4% of births [Scrimshaw & Backes, 2020]

*Tables are created solely for the purposes of this report by author

HRIs - Netherlands				
	Sexual & Reproductive Health	**Maternal Mortality & Healthcare**	**Prevention, Treatment, & Control of Diseases**	**Accessibility to Health Facilities & Essential Medicines**
Structure	Time frame and coverage of national policy on abortion: (2022) abortion considered lawful until 24th week of pregnancy [Ministry of Health, 2023]	Coverage of national policy on maternal health: (2006) Royal Dutch Association of Midwives initiated [Simmons, 2012]	Coverage of domestic laws for implementing the right to health: Article 22(1) of Dutch Constitution acknowledges promotion of public health [Flood & Gross, 2015]	Estimated proportion of births recorded through vital registration systems: (2021) ~100% recorded [UNICEF Data, n.d-a]
Process	Proportion of births attended by skilled personnel: (2019) ~100% attended [UNICEF & World Bank, n.d.-a]	Proportion of females of adolescent age educated on sexual, reproductive or maternal health issues in a traditional school setting: (2018) ~100% educated on issue [Katz, 2018]	Proportion of pregnant women immunized against Tdap: (2021) ~70% of pregnant women immunized [Immink et al., 2023]	Density of physicians: (2018) ~4.1 physicians per 1,000 residents [World Health Organization's Global, n.d.-a]
Outcome	Contraceptive prevalence: (2013) ~73% of married women ages 15-49 used [Household surveys & World Bank, n.d.-a]	Maternal mortality rate: (2021) ~4 deaths per 100,000 births [WHO et al., n.d.-a]	Life expectancy at birth: (2021) 81 years [United Nations Population, 2022a]	Proportion of births in a hospital setting: (2019) 83.7% of births [Galková et al., 2022]

* Tables are created solely for the purposes of this report by author

6.3 - Discussion of Findings from Case Study

Utilizing these HRIs in the tables above, the US and the Netherlands present similar findings in structural indicators; however, while the Netherlands protects the right to abortion for a pregnant female until 24 weeks, the US has recently overturned the Supreme Court decision Roe v. Wade concerning rights to abortion access, an important factor that may negatively influence these findings in the years to come. With regard to the process and outcome indicators, significant variations in maternal mortality rates, density of physicians, and proportion of births in a hospital setting are of note. For all of these factors, the US scores considerably lower than the Netherlands and a further look into these findings is necessary to understand their implications on the right to health.

Because the US currently does not face a humanitarian crisis and is considered a developed country, its maternal mortality rate of 21 deaths per 100,000 live births in 2021 does score better than the global average. However, the US's trend in maternal mortality has significantly worsened in recent years, jumping by almost 200% between 2000 and 2020 (Rabin, 2023a). Demonstrating this trend, the US maternal mortality rate in 2018 was 17 per 100,000, a score more than two times higher than that of other high-income countries and the highest of any developed country (Tikkanen et al., 2020). Making matters worse, an estimated 50% of the pregnancy-related deaths that occur each year are considered preventable by healthcare workers (U.S. Department of Health, n.d.).

Poor maternal health in the US is further evidenced by the rates of maternal mortality for minority populations. The maternal mortality rate for Black and Native American women who are pregnant and give birth in the US is actually three times higher than the rate for White women, standing at 55.3 deaths per 100,000 births – the table above portrays the average maternal mortality rate for all American women, masking these disparities (Rabin 2023a). Paradoxically, these increased rates are also heightened for these women of color regardless of their socioeconomic status. For example, a Black or Native American woman who is younger, has attained a higher education level, and is wealthier than a White woman – three socioeconomic factors that positively correlate with successful pregnancies and low maternal mortality rates – *still* has a three times higher chance of

dying from pregnancy-related causes than a White woman in the US (Tikkanen et al., 2020).

The US's high level of maternal mortality partially stems from an overall shortage of maternity care providers relative to births, low usage of midwifery-led care models, insurance limitations, and a multitude of socioeconomic factors that further hinder access to quality care during pregnancy, childbirth, and postpartum. Maternal mortality rates occurring during postpartum are especially important to consider, as 52% of maternal deaths occur during this time (see: *Figure IV*) (Rabin, 2023a; Tikkanen et al., 2020).

With regard to the US's lower density of physicians to population, a further distinction regarding OBGYN-specific care is necessary. As of 2020, over 50% of rural community hospitals located in the US did not provide any form of obstetrics care, a number that continues to rise daily as hospitals close their obstetrics units due to lack of funding caused by insurance issues and reductions in federal aid (Rabin, 2023a). With close to 50 million US residents residing in rural areas, the equivalent of 15% of the total population, this lack of maternity care affects millions of women throughout the country (Dobis et al., 2021). Further, women of color, indigenous groups, and impoverished women, a vulnerable demographic that already faces many complications throughout pregnancy and birth, are also most affected by these closures as they comprise a large portion of the overall rural demographic. The maternity care that is offered at these rural hospitals is especially important, as it also provides health care sensitive to cultural and religious needs of the communities served. Without this culturally sensitive feature of maternal health care and health care in general, many women and their families opt to forgo treatment at the hospital, and attend far fewer doctor's appointments throughout their pregnancy, further compounding the issue. Similarly, if complications arise during pregnancy or childbirth, a woman living in a rural area may have to drive hundreds of miles to seek healthcare, taking more time out of her day and requiring more money spent on gas to get there (Rabin, 2023a). These impediments to maternal health care in rural communities are only aggravated by the socioeconomic conditions plaguing all US populations.

At the national level, the US might address this shortage of maternity care providers by introducing and encouraging the use of midwifery-led care, a practice favored in many industrialized countries around the world, including the Netherlands. Only 12 in 1,000 live births in the US utilize midwives, a number two to six times lower than that of other developed countries. Even though the WHO has acknowledged that midwifery-led care is an evidence-based approach to reducing maternal mortality, the US healthcare system continues to favor hospital-led maternal healthcare regardless of the situation (Tikkanen et al., 2020).

Similarly, many other developed countries, including the Netherlands, guarantee a visit from a healthcare provider at least once in the first week following childbirth to ensure that both mother and child are doing well. The US does not. The issue of maternal leave is comparable. Most developed countries offer over 12 weeks paid leave for new mothers, with the Netherlands offering at least 16 weeks. The US, on the other hand, is the only high-income country that guarantees *zero* weeks paid maternity leave (Tikkanen et al., 2020). This lack of paid maternity leave in the US puts a tremendous economic strain on families, as taking time off from work to care for a newborn child often reduces the family income by half. Further, choosing to continue working in the weeks immediately following birth puts a tremendous physical strain on the mother's body and also necessitates childcare, another financial obligation. In such circumstances, families must make complicated decisions regarding work and childcare.

This evidence demonstrates that access to financial and physical capital, such as the US possesses, does not necessarily translate to better quality healthcare. Underlying social determinants of health like gender, race, physical environment, and social policies have a much larger impact on the availability of, access to and quality of maternal healthcare a woman in the US has or does not have, than may have once been thought. The state of maternal health and the quality of maternal healthcare available are impacted by the degree of direct and indirect discrimination a woman faces throughout her pregnancy, at the time of childbirth, and following childbirth. This discrimination is embedded in the healthcare system, perpetuated by healthcare providers, and/or influenced by underlying factors – all circumstances that the US government must directly address, in tandem with the relevant

health experts and health system administrators, in order to ensure the highest possible level of human rights attainment for women during maternity.

Overall, the selection of HRIs with regard to maternal health in this example has generated an extensive table to overview the state of maternal health in the US and the Netherlands. This table provides insight into a multitude of maternal health-related findings that are directly and indirectly linked to the right to health. The process described to create HRIs is relatively straightforward and provides a table easily read by government actors and human rights activists. Further, the case study demonstrates that a cross-country analysis utilizing the HRIs is not only possible but also helpful.

On the other hand, while the HRIs in this case study regarding the quality of maternal health and maternal healthcare in the US and the Netherlands provide an indication of the state of the right to health in these two countries, the HRIs do not include key findings that may be impactful. For instance, while the HRIs can measure density of physicians as a proxy for accessibility to healthcare, the quality of this healthcare is not accounted for. Quality of healthcare is important, for it indicates the level of healthcare received and the cultural and religious sensitivities of such care. Lack of quality healthcare may lead to additional hospital visits, exacerbate certain diseases, and discourage certain demographics from pursuing physician-led care in the future. Similarly, a focus on quantitative measurements discourages the use of surveys and expert opinions that may provide further insight into a region's maternal health practices. Surveys and expert opinions may better incorporate the attitudes of relevant populations and the specialized recommendations necessary for maternal health policies that guarantee a right to health. Further, the HRIs selected do not allow for descriptions of pertinent existing policies in the US and the Netherlands that impact access to maternal healthcare. Therefore, stakeholders may have difficulty determining what is leading to these figures in the first place.

6.4 - Additional Human Rights-Based Approaches to Consider

In addition to formulating accurate and effective indicators to measure health-related human rights conditions, other foundational elements exist that stakeholders must address at both the national and international levels. A crucial step to evaluating maternal morbidity and mortality through a human rights-based approach requires all relevant actors

to both recognize and acknowledge that the deaths and injuries sustained by women during this time are not largely inevitable, and are rather linked to laws and practices (or lack thereof) that are discriminatory in nature, and often fail to ensure adequate safety within health systems. Without this initial concession from duty bearers, efforts to hold people accountable for preventable maternal health wrongdoings, as well as for other human rights violations, will be much more difficult. A lack of responsibility and commitment from these duty bearers can create future obstacles to evaluating and improving maternal health using a human-rights based process (United Nations, 2020).

Another essential step is to improve access to reproductive and maternal health-related information for women and girls. Endowing women and girls with accurate and comprehensive resources of this sort best allows them to make informed maternity-related decisions, based on both human rights and their health specifics. Further, women during pregnancy and childbirth risk encountering gender-based and racial-based discrimination not only from healthcare workers and practitioners, but employers as well. These prejudices are aggravated by other socioeconomic factors that lead to unsafe living conditions and further hinder access to adequate maternal healthcare and treatments (Kenyon et al., 2018).

Conclusion

Although questions regarding the quality of information and oversimplification of the complexity of human rights are valid with regard to the HRI process, HRIs do provide explicit and clear data findings that allow for quick comparisons by stakeholders across regions and offer a degree of impartiality that other measurement methods inherently lack. HRIs effectively maintain equity amongst all human rights and allow for the transformation of targets and benchmarks into necessary human rights policies. Overall, HRIs offer a reliable and verifiable measurement method that can effectuate necessary change in the field of human rights, and their shortcomings should not completely overshadow their benefits.

While concerns about indicator standardization and the increasing preference for a systematic paradigm to evaluate human rights, as encouraged by the OHCHR's development of HRIs, are rooted in fact, and the limitations of such methods are clearly evident, viewing the HRIs as complementary tools for human rights measurements and not 'one-size-fits-all' may be the best approach. The HRIs are a way for countries that do not already have access to pre-existing human rights measurement tools to increase data aggregation and improve their human rights protections. For countries that already have preferred measurement tools that provide adequate data, HRIs may take less priority or merely supplement existing methodologies.

To this end, it is important to remember that the central purpose of the *Human Rights Indicators* as intended by the OHCHR is to facilitate the development of human rights-specific indicators to be used as proxies for measuring human rights attainment. The guide does not in itself provide governments and civil society organizations with all-specific indicators to use in these situations. Instead, it provides a comprehensive paradigm, as well as step-by-step directions, that governments and organizations can use to develop their own indicators (OHCHR, 2012). This paradigm allows for country-specific and even region-specific HRI selection in order to better measure human rights conditions around the globe.

While this lack of universal HRI specification in the *Human Rights Indicators* allows stakeholders agency to select their own HRIs and maintain sovereignty over their

human rights practices, the guide's vagueness may compromise the effectiveness of HRI application. On the other hand, if the HRIs are streamlined and adopted by multiple countries to portray the same human rights, such standardization may facilitate cross-country analysis, as demonstrated in this report's case study. Creating a standardized set of HRIs may lead to more 'useable' data findings for stakeholders, as government officials and other relevant actors can directly compare human rights standards in one country versus another, allowing for easier and quicker identification of what works and what does not work. Ultimately, this will result in better human rights policies and practices in any given region, and citizens will be able to enjoy human rights to their fullest extent.

With regard to health-specific scenarios, the HRI framework lacks certain features particular to the health sector and does not provide a comprehensive overview regarding human rights practices particular to the right to health. This inapplicability to the health and public health fields is a major limitation to HRIs, as many human rights are linked, directly or indirectly, to the quality of health and healthcare available within a region. To this end, using HRIs to measure maternal health quality, as demonstrated in chapter 6, does not sufficiently portray the maternal health conditions present in the US and the Netherlands. Consequently, changes to the HRIs and their implementation process are needed before their wide-scale adoption in these fields is possible.

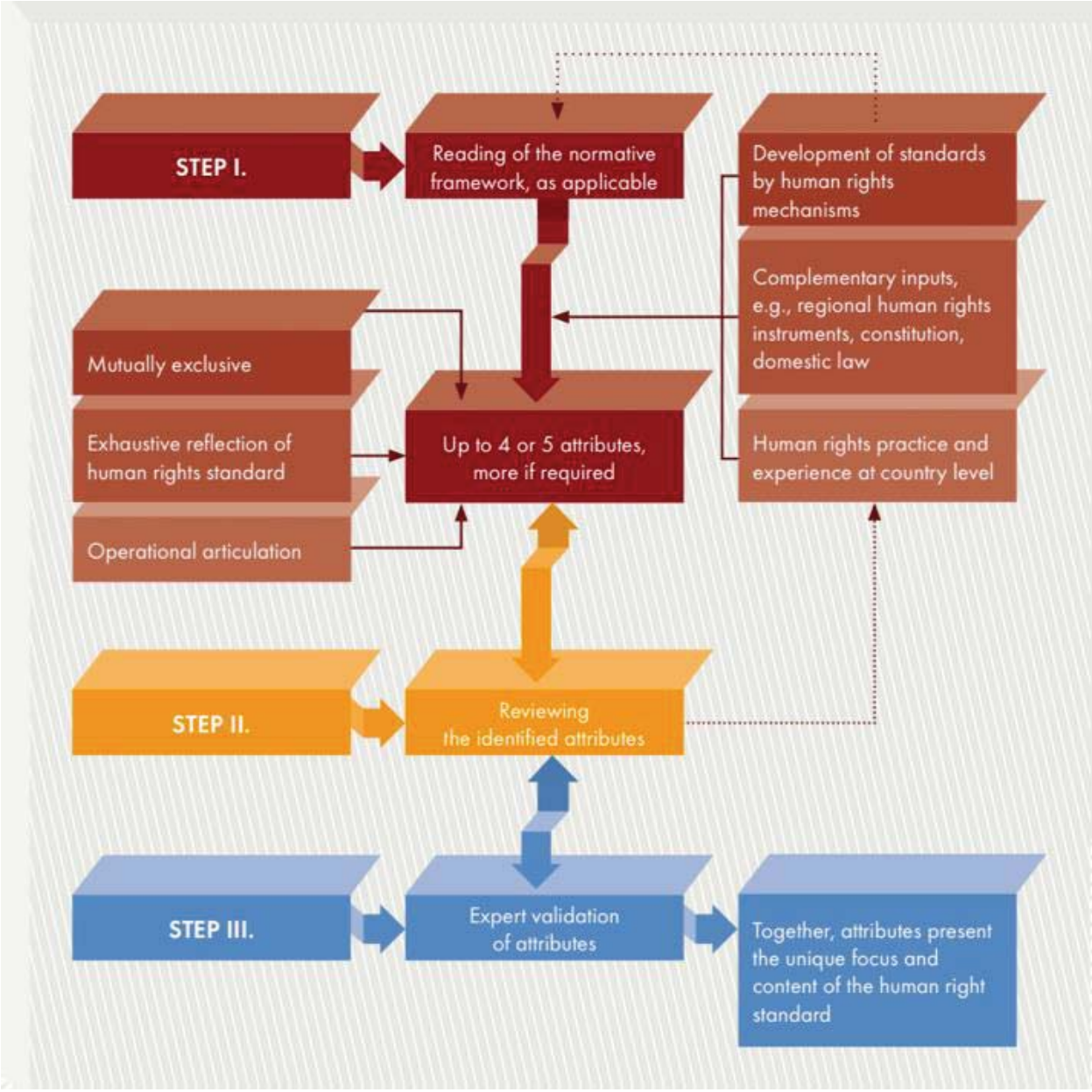
Once these limitations are addressed, HRIs possess the ability to greatly transform the field of human rights, for HRIs at their foundation strive to promote the three pillars of human rights concerning the obligations of duty bearers to protect, respect and fulfill all human rights for their citizens. By increasing transparency and accountability for human rights through effective measurement of human rights conditions, duty bearers will ensure that citizens can enjoy the highest attainment of human rights possible, ultimately improving quality of life for all persons around the world.

List of Acronyms

Acronym	Definition
CDC	Centers for Disease Control & Prevention
HRC	Human Rights Council
HRI	Human Rights Indicator
IAG	Indicator Advisory Group
ICCPR	International Covenant on Civil & Political Rights
ICESCR	International Covenant on Economic, Social & Cultural Rights
NIH	National Institutes of Health
OHCHR	Office of the High Commissioner for Human Rights
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization

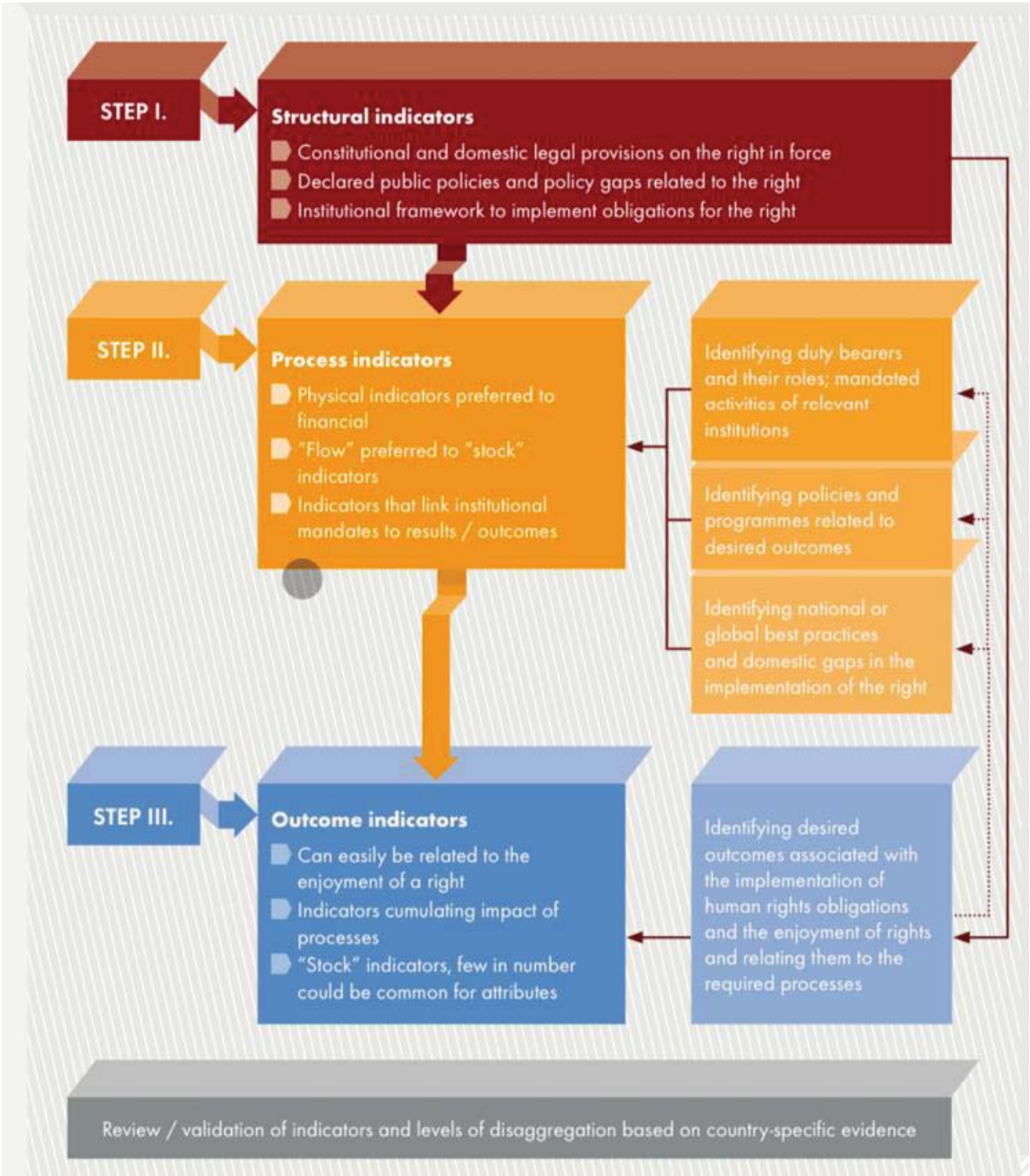
Figures

Figure I – Identifying Attributes in the HRI Selection Process



(OHCHR, 2012, p. 76)

Figure II – Selecting Structure-Process-Outcome Indicators for HRIs



(OHCHR, 2012, p. 78)

Figure III – Attributes and Indicators Selected for the Right to Health

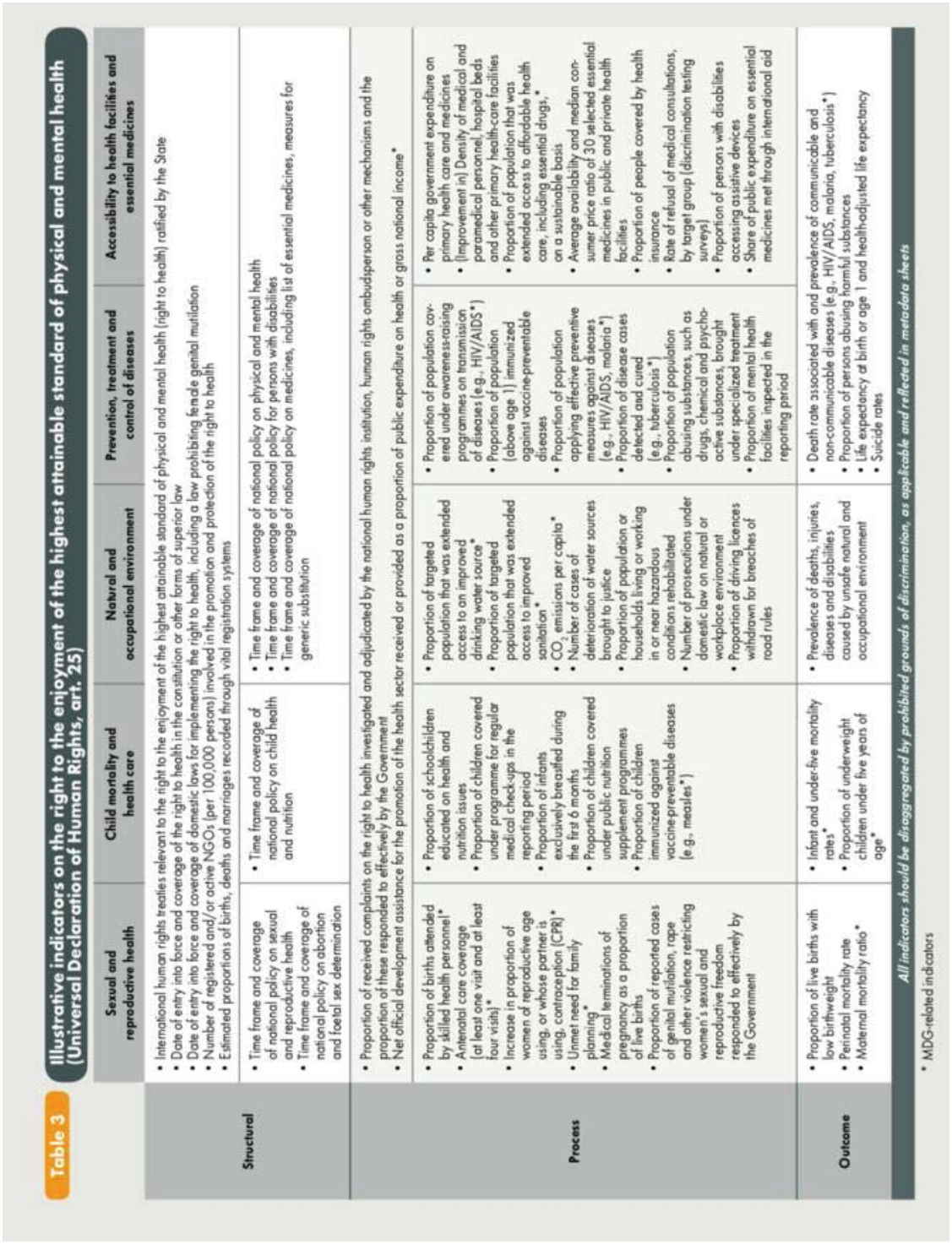


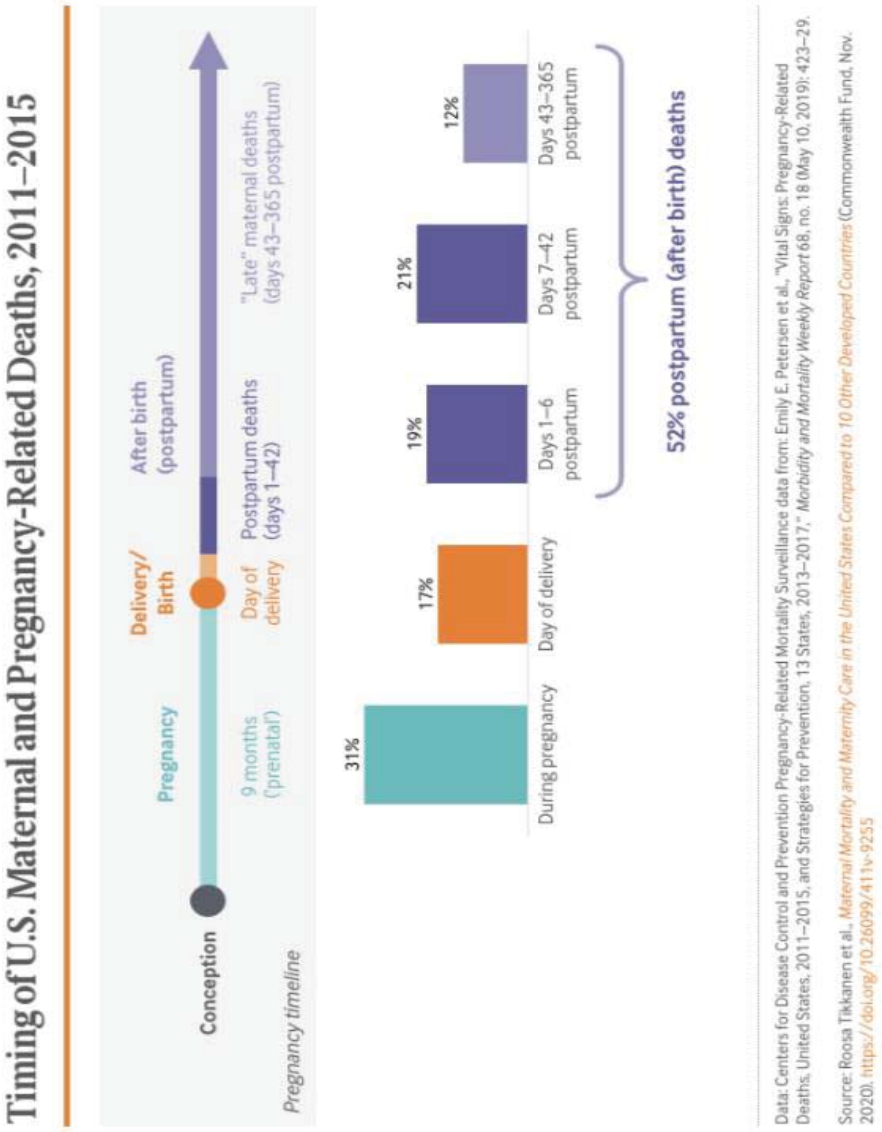
Table 3 **Illustrative indicators on the right to the enjoyment of the highest attainable standard of physical and mental health (Universal Declaration of Human Rights, art. 25)**

	Sexual and reproductive health	Child mortality and health care	Natural and occupational environment	Prevention, treatment and control of diseases	Accessibility to health facilities and essential medicines
Structural	• International human rights treaties relevant to the right to the enjoyment of the highest attainable standard of physical and mental health (right to health) ratified by the State • Date of entry into force and coverage of the right to health in the constitution or other forms of superior law • Date of entry into force and coverage of domestic laws for implementing the right to health, including a law prohibiting female genital mutilation • Number of registered and/or active NGOs (per 100,000 persons) involved in the promotion and protection of the right to health • Estimated proportions of births, deaths and marriages recorded through vital registration systems				
	• Time frame and coverage of national policy on sexual and reproductive health • Time frame and coverage of national policy on abortion and foetal sex determination	• Time frame and coverage of national policy on child health and nutrition	• Time frame and coverage of national policy on physical and mental health • Time frame and coverage of national policy for persons with disabilities • Time frame and coverage of national policy on medicines, including list of essential medicines, measures for generic substitution		
Process	• Proportion of received complaints on the right to health investigated and adjudicated by the national human rights institution, human rights ombudsperson or other mechanisms and the proportion of these responded to effectively by the Government • Net official development assistance for the promotion of the health sector received or provided as a proportion of public expenditure on health or gross national income*				
	• Proportion of births attended by skilled health personnel* • Antenatal care coverage (at least one visit and at least four visits)* • Increase in proportion of women of reproductive age using, or whose partner is using, contraception (CPR)* • Unmet need for family planning* • Medical terminations of pregnancy as a proportion of live births • Proportion of reported cases of genital mutilation, rape and other violence restricting women's sexual and reproductive freedom responded to effectively by the Government	• Proportion of schoolchildren educated on health and nutrition issues • Proportion of children covered under programme for regular medical check-ups in the reporting period • Proportion of infants exclusively breastfed during the first 6 months • Proportion of children covered under public nutrition supplement programmes • Proportion of children immunized against vaccine-preventable diseases (e.g., measles*)	• Proportion of targeted population that was extended access to an improved drinking water source* • Proportion of targeted population that was extended access to improved sanitation* • CO_2 emissions per capita* • Number of cases of deterioration of water sources brought to justice • Proportion of population or households living or working in or near hazardous conditions rehabilitated • Number of prosecutions under domestic law on natural or workplace environment • Proportion of driving licences withdrawn for breaches of road rules	• Proportion of population covered under awareness-raising programmes on transmission of diseases (e.g., HIV/AIDS*) • Proportion of population (above age 1) immunized against vaccine-preventable diseases • Proportion of population applying effective preventive measures against diseases (e.g., HIV/AIDS, malaria*) • Proportion of disease cases detected and cured (e.g., tuberculosis*) • Proportion of population abusing substances, such as drugs, chemical and psychoactive substances, brought under specialized treatment • Proportion of mental health facilities inspected in the reporting period	• Per capita government expenditure on primary health care and medicines • (Improvement in) Density of medical and paramedical personnel, hospital beds and other primary health-care facilities • Proportion of population that was extended access to affordable health care, including essential drugs,* on a sustainable basis • Average availability and median consumer price ratio of 30 selected essential medicines in public and private health facilities • Proportion of people covered by health insurance • Rate of refusal of medical consultations, by target group (discrimination testing surveys) • Proportion of persons with disabilities accessing assistive devices • Share of public expenditure on essential medicines met through international aid
Outcome	• Proportion of live births with low birthweight • Perinatal mortality rate • Maternal mortality ratio*	• Infant and under-five mortality rates* • Proportion of underweight children under five years of age*	• Prevalence of deaths, injuries, diseases and disabilities caused by unsafe natural and occupational environment	• Death rate associated with and prevalence of communicable and non-communicable diseases (e.g., HIV/AIDS, malaria, tuberculosis*) • Proportion of persons abusing harmful substances • Life expectancy at birth or age 1 and healthadjusted life expectancy • Suicide rates	
	All indicators should be disaggregated by prohibited grounds of discrimination, as applicable and reflected in metadata sheets				

* MDG-related indicators

(OHCHR, 2012, p. 90)

Figure IV – Timings of Maternal and Pregnancy-Related Deaths, 2011-2015



(Tikkanen et al., 2012, "What we mean by maternal mortality")

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