2022

Building a Bridge Between WASH in HCFs and the Right to Water Through the Lens of Maternal and Child Health

London Edgar

BUILDING A BRIDGE BETWEEN WASH IN HCFS AND THE RIGHT TO WATER THROUGH THE LENS OF MATERNAL AND CHILD HEALTH

*London Edgar**

ABSTRACT

Despite being recognized as a human right over a decade ago, the right to water has yet to achieve universal recognition. And although the proportion of births taking place in HCFs as opposed to home delivery has increased globally from 52 percent in 2000 to 76 percent in 2018, an estimated three million infants still die each year in the first month of life. This Essay will begin by discussing the right to water and the barriers to its implementation when framed solely as a human rights obligation. In the first section, it will specifically highlight sources that emphasize the right to water with regard to women and children. Next, this Essay will survey the recent efforts to ensure adequate WASH in HCFs and the impact these services can have on maternal and newborn health. Finally, this Essay will conclude by explaining that a focus on maternal and child health can serve as a bridge between the WASH in HCFs movement and the right to water movement, which has been stunted by the progressive realization requirement.

INTRODUCTION

In its 2019 World Health Statistics Report, the World Health Organization ("WHO") noted that in 2015, an estimated 303,000 women died during pregnancy and childbirth.[1] Maternal mortality was the second leading cause of death for women of reproductive age in 2016, with almost all maternal deaths (95 percent) occurring in low-income and lower-middle-income countries.[2]

In 2017, an estimated 5.4 million children under the age of five died, with almost half of all deaths (2.5 million) occurring during the first 28 days of life (known as neonatal mortality).[3] Neonatal mortality is often caused by conditions and diseases that are associated with either a lack of quality care at birth or a

* J.D., Emory University School of Law, Class of 2022.

1 *World Health Statistics 2019: Monitoring Health for the SDGs, Sustainable Development Goals*, WORLD HEALTH ORGANIZATION [WHO], at 10 (2019), https://apps.who.int/iris/bitstream/handle/10665/324835/9789241565707-eng.pdf

2 *Id.*

3 *Id.* at 16.

lack of skilled care and treatment immediately after birth.[4] Infections such as sepsis, meningitis, pneumonia, diarrhea, and tetanus account for one-quarter of all deaths during the neonatal period.[5]

One key aspect of facilitating hygienic birth and postnatal care, as well as implementing infection prevention control procedures, involves ensuring the availability of adequate water, hygiene, and sanitation services (collectively known as "WASH") at health care facilities ("HCFs").[6] In 2019, 1.8 billion people lacked basic water services at HCFs.[7] Among the least-developed countries, where maternal mortality is the highest, only 50 percent of HCFs had basic water service.[8] Further, in 2019, around 800 million people visited HCFs which lacked sanitation services, meaning that the facilities had either unimproved toilets or no toilets at all.[9] Not only can giving birth in a facility without proper WASH have negative effects on maternal and neonatal health outcomes, but it can discourage pregnant women from seeking care at hospitals altogether.[10] In a systematic review of the availability and quality of WASH in HCFs on care-seeking behavior, researchers concluded that although WASH status was not the main driver of patient satisfaction, poor WASH provisions were the reason many women chose home delivery.[11]

In 2014, academics and researchers from a wide variety of organizations, including WaterAid, the London School of Hygiene & Tropical Medicine, the United Nations Children's Fund ("UNICEF"), WHO, and the United Nations Population Fund, issued a joint call to action on improving WASH for maternal and newborn health, explaining that "linking investments in [WASH] presents

---

[4] *Id.* at 17.

[5] Joanna Esteves Mills, et. al, *Determinants of Clean Birthing Practices in Low- and Middle-Income Countries: a Scoping Review*, 20 BMC PUB. HEALTH 1, 2 (2020), https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-020-8431-4.pdf.

[6] *Id.*

[7] *Global Progress Report on Water, Sanitation and Hygiene in Health Care Facilities: Fundamentals First*, WHO, at 20 (2020), https://www.washinhcf.org/wp-content/uploads/2020/12/9789240017542-eng-1.pdf [hereinafter *Fundamentals First*].

[8] *Id.*

[9] *Id.*

[10] *Water, Sanitation and Hygiene in Health Care Facilities: Status in Low and Middle Income Countries and way Forward*, WHO, at 1 (2015), https://apps.who.int/iris/bitstream/handle/10665/154588/9789241508476_eng.pdf;jsessionid=342D74C1385BEB6C4626BE87259E1675?sequence=1 [hereinafter WASH in HCF: Status in LMIC].

[11] Maya Bouzid, Oliver Cumming, and Paul R. Hunter, *What is the Impact of Water and Hygiene in Healthcare Facilities on Care Seeking Behavior and Patient Satisfaction? A Systematic Review of Evidence From Low-Income and Middle-Income Countries*, BMJ GLOB. HEALTH 1, 1 (2018), https://gh.bmj.com/content/bmjgh/3/3/e000648.full.pdf.

an overlooked but potentially important opportunity for progress."[12] In 2015, researchers from the London School of Hygiene & Tropical Medicine and BRAC, an international development organization based in Bangladesh, explored the link between WASH and maternal health by creating a conceptual framework and conducting a scoping literature review and concluded that "while major gaps exist, the evidence strongly suggests that poor WASH influences maternal and reproductive health outcomes to the extent that it should be considered in global and national strategies."[13]

I. THE RIGHT TO WATER AND BARRIERS TO ITS IMPLEMENTATION

A. Sources of the Right to Water with an Emphasis on Women and Children

In 2002, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) through General Comment No. 15 incorporated the universal right to water, deeming it "fundamental for life and health."[14] The United Nations (U.N.) Economic and Social Council's Committee on Economic, Social, and Cultural Rights ("CESCR") also noted that the human right to water is "a prerequisite for the realization of other human rights,"[15] such as "the highest attainable standard of health."[16]

What exactly does the right to water entail? CESCR explained that the right to water "contains both freedoms and entitlements."[17] The freedoms include "the right to maintain access to existing water supplies . . . , and the right to be free from interference, such as the right to be free from arbitrary disconnections or contamination of water supplies."[18] The entitlements, which this Article will primarily focus on, include "the right to a system of water supply and management that provides equality of opportunity for people to enjoy the right to water."[19]

---

[12] Yael Velleman, et al., *From Joint Thinking to Joint Action: A Call to Action on Improving Water, Sanitation, and Hygiene for Maternal and Newborn Health*, 11 PLOS MED 1, 1 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4264687/pdf/pmed.1001771.pdf.

[13] Oona M.R. Campbell et al., *Getting the Basic Rights – the Role of Water, Sanitation and Hygiene in Maternal and Reproductive Health: a Conceptual Framework*, 20 TROPICAL MED. AND INT'L HEALTH 252, 252 (2015).

[14] Michael R. Ulrich, *The Impact of law on the Right to Water and Adding Normative Change to the Global Agenda*, 48 GEO. WASH. INT'L L. REV. 43, 48 (2015).

[15] CESCR, General Comment No. 15: The Right To Water, U.N. Doc. E/C.12/2002/11, ¶ 1 (2003) [hereinafter General Comment No. 15].

[16] *Id*. ¶ 3.

[17] *Id*. ¶ 10.

[18] *Id*.

[19] *Id*.

The right to water and sanitation was not explicitly recognized by the U.N. General Assembly ("GA") until 2010, when the GA announced that it was "deeply concerned that approximately 884 million people lack access to safe drinking water and . . . more than 2.6 billion people do not have access to basic sanitation."[20] The GA noted the health and educational effects that a lack of access to clean water and sanitation can have on vulnerable populations such as children, and stated that it was "alarmed that approximately 1.5 million children under 5 years of age die…as a result of water-and sanitation-related diseases."[21]

A few months later, the Human Rights Council ("HRC") adopted the GA's resolution, affirming that "the human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity."[22] The HRC also mentioned other human rights law instruments that detail obligations for States Parties

regarding the right to clean water and sanitation, such as the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") and the Convention on the Rights of the Child ("CRC").[23]

Article 2 of the CEDAW obligates States Parties to "condemn discrimination against women in all forms."[24] CEDAW makes explicit in Article 3 that "adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention."[25] In regard to adequate WASH, Article 14 directs States Parties to "take into account the particular problems faced by rural women" and "ensure to such women the right . . . to enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport, and communications."[26] One example of a particular problem faced by rural women is having to travel long distances to fetch water. In 2017, 206 million people lacked a basic drinking water service and had to spend over 30 minutes per round trip to collect water.[27]

---

[20] G.A. Res. 64/292, The Human Right to Water and Sanitation (Jul. 28, 2010) [hereinafter The Human Right to Water and Sanitation].

[21] *Id.*

[22] Human Rights Council Res. 15/9, Human rights and access to safe drinking water and sanitation (Oct. 6, 2010) [hereinafter Human Rights and Access to Safe Drinking Water and Sanitation].

[23] *Id.*

[24] Convention on the Elimination of All Forms of Discrimination Against Women, U.N., Article 1(1) (Dec. 18, 1979) [hereinafter CEDAW].

[25] *Id.*

[26] *Id.*

[27] Jo-Anne L. Geere and Paul R. Hunter, *The association of water carriage, water supply and sanitation*

As explained above, the CESCR explained that the right to water contained both freedoms and entitlements, with individuals being entitled to the "equality of opportunity" to enjoy the right to water.[28] The second Special Rapporteur on the Human Rights to Safe Drinking Water and Sanitation, Leo Heller, noted in 2016 that gender inequalities in the water and sanitation sector are "pervasive" and that they occur at "every stage of a woman's life—through childhood, adolescence, parenthood, illness and old age."[29]

Cultural, social, economic, and biological differences between men and women contribute to disparities in access, use, experiences, and knowledge of water and sanitation.[30] Heller advised that laws, policies, and programs should "not inadvertently reinforce gender stereotypes, but should seek to transform them."[31] To do so, Heller argued it is "important that policies and strategies explicitly mention the different experiences of men and women and marginalized groups."[32] In its 2020 progress report on WASH in HCFs, WHO listed many reasons why WASH in HCFs is a non-negotiable, with two key reasons being that (1) it is a human rights, dignity, gender, and social justice issue; and (2) it is a top priority of women receiving maternal care.[33] The report stressed that WASH services have the effect of "uphold[ing] the dignity and human rights of all care-seekers," particularly in regard to vulnerable and marginalized populations, such as mothers, newborns, and children.[34]

While access to sanitation facilities is often limited due to taboos surrounding menstruation, coming into direct contact with water can also provide problems for women, as women are in the "greatest physical contact" with contaminated water due to their domestic responsibilities and caretaking roles.[35] One example of a water-based infection that affects women of reproductive age is urogenital schistosomiasis.[36] An estimated 10 million

---

usage with maternal and child health. A combined analysis of 49 Multiple Indicator Cluster Surveys from 41 countries, 223 INT'L J. OF HYGIENE AND ENVIR. HEALTH 238 (2020), https://reader.elsevier.com/reader/sd/pii/S1438463919303669?token=228D43B81736C98E898A05DC1DAFC96E7BB137C2BB48618000986F652BB7965B74020B2AD43C016072F7411574E092E6.

[28] General Comment No. 15, *supra* note 15.

[29] Human Rights Council, Rep. of the Special Rapporteur on the human right to safe drinking water and sanitation, U.N. Doc. A/HRC/33/49 ¶ 3 (Jul. 27, 2016) [hereinafter Rep. of the Special Rapporteur].

[30] *Id.* ¶ 1.

[31] *Id.* ¶ 11.

[32] *Id.*

[33] Fundamentals First, *supra* note 7 at 9.

[34] *Id.*

[35] Rep. of the Special Rapporteur, *supra* note 29, ¶ 32.

[36] Wellington Murenjekwa, et. al, *Determinants of Urogenital Schistomiasis Among Pregnant Women and its Assicaotion with Preganancy Outcomes, Neonatal Deaths, and Child Growth*, THE J. OF INFECTIOUS

African women per year suffer from schistosomiasis during pregnancy.[37] Women can become infected through contact with freshwater-dwelling larval schistosome, which penetrate the skin and mature into adult worms that inhabit urogenital blood vessels.[38] The adult worms continuously produce eggs, which can cause chronic tissue damage.[39] Research has shown that the odds of being infected with schistosomiasis were higher among women without an improved latrine or improved source of drinking water.[40] The disease is associated with cervical cancer, ectopic pregnancy, and infertility, as well as anemia, undernutrition, and inflammation in pregnant women.[41] Schistosomiasis can also affect fetal immune response, resulting in inflammation, and can cause low birthweight.[42]

Like the CEDAW, the CRC also imposes obligations on States Parties whose fulfillment is linked to the provision of clean water and sanitation. The "inherent right to life" of every child, as well as "the right of the child to the enjoyment of the highest attainable standard of health" are fundamental tenants of the CRC, under which State Parties are obligated to "ensure to the maximum extent possible the survival and development of the child."[43] In order to do so, States Parties to the CRC agree to take appropriate measures "to diminish child and infant mortality; to combat disease and malnutrition, including within the framework of primary health care, through . . . the provision of adequate nutritious foods and clean drinking-water," and "to ensure appropriate pre-natal and post-natal health care for mothers."[44] An example of a preventable disease linked to poor WASH that affects newborns is sepsis, an invasive infection normally caused by bacteria that is acquired either shortly before, during, or after delivery.[45] Newborns can come into contact with the infection-causing bacteria through the mother's blood, skin, or birth canal before or during delivery, as well as from the environment after delivery.[46] In either case, WASH practices of both

---

DISEASES 1, 1 (2019), https://academic.oup.com/jid/advance-article/doi/10.1093/infdis/jiz664/5674952.

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] Campbell, *supra* note 13 at 56.

[42] *Id.*

[43] G.A. Res. 44/25, Convention on the Rights of the Child (Nov. 20, 1989) [hereinafter CRC].

[44] *Id.*

[45] *Healthy Start: the first month of life*, WaterAid, at 4 (Feb 2015), https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/WaterAid_Healthy_Start_The_First_Month_Of_Life_US_version.pdf.

[46] *Id.*

the healthcare staff and the mothers in birth facilities can reduce the risk of infection.[47]

B. Common Violations of the Right to Water and Sanitation

In 2014, Catarina de Albuquerque, the first Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation, published a report that enumerated several common violations of the right to safe drinking water and sanitation.[48] In the report's introduction, she quoted the CESCR's statement that the international community "tolerate[s] all too often breaches of economic, social, and cultural rights, which, if they occurred in relation to civil and political rights, would provoke expressions of horror and outrage that would lead to concerted calls for immediate remedial action."[49]

Under the Optional Protocol to the ICESCR, States Parties must apply "maximum available resources" towards the progressive realization of rights.[50] Ultimately, they must "fully realize the rights to water and sanitation by ensuring access to sufficient, safe, acceptable, accessible, and affordable water and sanitation services for all."[51] A State Party's failure to comply with its human rights obligations under the Optional Protocol constitutes a violation.[52]

1. Violations of the Obligation to Fulfill the Right to Water

Special Rapporteur de Albuquerque argued that while violations of the obligation to fulfill the right to water and sanitation may constitute "the most critical category," they "have generally received the least attention."[53] Violations of this category include failure to develop, implement, and monitor strategies, plans, and programs; failure to properly raise, allocate, and utilize the maximum available resources; and the failure to prioritize the necessary steps to ensure minimum essential levels of access to water and sanitation.[54]

Under Article 2 of the ICESCR, the steps that States Parties take to achieve the full realization of the enumerated rights must be "deliberate, concrete, and

---

47 *Id.*

48 Human Rights Council, Report of the Special Rapporteur on the human right to safe drinking water and sanitation, Catarina de Albuquerque, U.N. Doc. A/HRC 27/55 (Jun. 30, 2014) [hereinafter Common Violations of the Human Rights to Drinking Water and Sanitation].

49 *Id.* at 3.

50 *Id.* at 5.

51 *Id.*

52 *Id*.

53 *Id.* at 11.

54 *Id.*

targeted as clearly as possible."[55] If resource constraints prohibit a State from fully recognizing a right, such as the right to water and sanitation, the State must immediately adopt a strategy to achieve full realization, and to monitor progress.[56] Violations of the obligation to fulfill can include the failure: to design and implement a strategy based on human rights standards and principles; to identify and meet targets in line with human rights standards; to ensure effective monitoring and accountability; and to target vulnerable or marginalized communities, such as mothers and children.[57]

WHO, on behalf of UN-Water, publishes a yearly Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) in order to monitor components of WASH systems, such as governance, monitoring, finance, and human resources.[58] The 2019 GLAAS report revealed that 94 percent of countries surveyed had national policies or plans for drinking-water and sanitation in place, while 78 percent had policies or plans for hygiene.[59] However, national plans alone are not enough to ensure sufficient WASH. The data indicates that although over 77 percent of countries have developed cost estimates for the implementation of their drinking-water and sanitation plans, less than 15 percent of them have secured sufficient financing to implement their plans.[60]

2. *Violations of the Obligation to Refrain from Discrimination and Ensure Substantive Equality*

As noted earlier, the prohibition against discrimination in CEDAW, which takes effect upon ratification, allows for "differential treatment and other measures designed to eliminate systemic or structural discrimination."[61] States Parties not only have a negative obligation to avoid discriminatory measures, but also a positive obligation to "immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination."[62] Violations of the obligation

---

[55] *Id*

[56] *Id.*

[57] *Id.*

[58] *National systems to support drinking-water, sanitation and hygiene: global status report 2019*, WHO, at 1 (2019), https://reliefweb.int/sites/reliefweb.int/files/resources/9789241516297-eng.pdf [hereinafter 2019 GLAAS Report].

[59] *Id.* at 5.

[60] *Id.* at 7.

[61] Common Violations of the Human Rights to Drinking Water and Sanitation, *supra* note 48, at 16.

[62] *Id. (*quoting CESCR, General Comment No. 20: Non-discrimination in economic, social, and cultural rights, ¶ 8 (May 2009).

to refrain from discrimination and to ensure substantive equality can be grouped into the following categories: (1) exclusion of groups or individuals from services or facilities, or failure to take measures to achieve substantive equality and address systemic patterns of inequalities; (2) failure to reasonably accommodate persons with disabilities and to take into account particular requirements; (3) failure to prevent and combat discrimination and stigmatization in the private sphere, or endorsement of stigmatizing practices through State action; and (4) failure to monitor inequalities in access to water and sanitation and to collect disaggregated data for that purpose.[63]

In May 2015, shortly after the Rapporteur's 2014 Report summarizing violations of the right to water and sanitation, U.N.-Water published a report providing guidance on how to promote non-discrimination and equality in the context of fulfilling the right to water and sanitation, particularly in regard to women and girls.[64] The report highlights the many ways that women and girls experience discrimination and inequalities in relation to their enjoyment of the human rights to water and sanitation: they bear the primary responsibility for domestic tasks, such as collecting water; they are most vulnerable to severe consequences from water and sanitation-related diseases during pregnancy; and they are known to drop out of school not only to fulfill their domestic responsibilities, but because of lack of access to sanitation and menstrual hygiene facilities.[65]

Under human rights law, individuals are "right-holders" who are entitled to water and sanitation, while States are "duty-bearers" that must guarantee access to WASH services to all individuals on an equal and non-discriminatory basis.[66] To identify and better understand discriminatory processes, States Parties should disaggregate data in order to reveal existing inequalities and pinpoint "why, where, and how" discrimination occurs.[67]

One example of using data to pinpoint discriminatory processes is a report by researchers from the University of East Anglia in the United Kingdom and Tshwane University of Technology in South Africa, who merged 49 Cluster Surveys from 41 countries in order to analyze the association of water fetching, unimproved water supplies, and the usage of improved sanitation facilities with

---

[63] *Id.*

[64] *Eliminating Discrimination and Inequalities in Access to Water and Sanitation*, UN-WATER (May 2015), https://www.unwater.org/publications/eliminating-discrimination-inequalities-access-water-sanitation/.

[65] *Id.* at 10–11.

[66] *Id.* at 17.

[67] *Id.* at 19.

indicators of maternal and child health.[68] Their results showed that fetching water is associated with poorer maternal and child health outcomes, but the health effects are conditioned on who collects that water.[69] When adults in the household collect water, there is an increased relative risk of childhood death, likely due to a lack of supervision or an inability to provide needed care when children are left alone while the adults make the journey to retrieve water.[70] When women or girls bear the responsibility for fetching water, there is also a correlation with a decreased uptake of antenatal care.[71] With an improved water supply source within the home, a woman would have a greater opportunity to "ask for and receive social support in the prenatal period, which could then facilitate her access to antenatal care, or to travel and give birth in a HCF."[72]

C. The Slow March of Progressive Realization[73] of the Right to Water

In his article on the impact of law on the right to water, Michael Ulrich, a leading public health law scholar, argued that the justification for "the progressive realization principle that applies to economic, social, and political rights [which] is supposedly in place due to resources these rights command and the limited resources some countries have to address them" does not hold water, so to speak.[74] He suggests that the primary difference between the two categories of rights (positive and negative) is one related to ease of fulfilment, as "simply passing legislation can fulfill civil and political rights."[75] He noted that the resource demand explanation has become an excuse for inaction when it comes to social, cultural, and economic rights, which "under the auspices of progressive

---

[68] Geere, *supra* note 27.

[69] *Id.*

[70] *Id.* at 238–39.

[71] *Id.*

[72] *Id.*

[73] Progressive realization is a frequently-used term in international law documents that address human rights. Ulrich, *supra* note 14, at 51. States Parties to the ICESCR agree to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures." *Id.* In contrast, States Parties to the International Covenant on Civil and Political Rights (ICCPR) are required to "respect . . . and ensure" the rights declared by the Covenant. *Id.* This difference in expectations regarding the timeline for fulfillment might be explained by the distinction between positive and negative obligations. *Id.* Under the ICCPR, States Parties primarily have negative obligations to "refrain from acts that inhibit individual liberties." *Id.* However, under the ICESCR, States Parties have more time-consuming positive obligations that require them to take "action to implement[] the rights [enshrined in the treaty]." *Id.*

[74] *Id.* at 52.

[75] *Id.*

realization, have become more akin to aspirational goals than realistic benchmarks for states."[76]

At the 45th session of the Human Rights Council in fall 2020, the third Special Rapporteur addressed the progressive realization of the human rights to water and sanitation, noting that 2020 was important for two reasons: it marked both a decade since water and sanitation were explicitly recognized as a human right by the GA, and it marked a decade remaining to achieve the Sustainable Development Goals ("SDGs").[77] The Special Rapporteur acknowledged an assertion similar to Ulrich's that "both the [SDGs] and the progressive realization obligation have been criticized for being aspirational goals . . . the latter because it is viewed as vague, having no defined time frame or pace of implementation and therefore not imposing a clear positive obligation on States."[78]

In Resolution 70/1, which introduced the 2030 Agenda for Sustainable Development, the GA envisioned "a world where we reaffirm our commitments regarding the human right to safe drinking water and sanitation and where there is improved hygiene."[79] It also committed countries to "accelerating the progress made to date in reducing newborn, child, and maternal mortality by ending all such preventable deaths before 2030."[80] It is important to note that the follow-up and review processes mentioned in the 2030 Agenda for Sustainable Development are to be "voluntary and country-led" and will "take into account different national realities, capacities and levels of development and will respect policy space and priorities," which gives great discretion to the States Parties and does not set out a viable enforcement mechanism.[81]

Goal 6 of the SDGs is to "ensure access to water and sanitation for all."[82] Under Goal 6.1, the target is to "achieve universal and equitable access to safe and affordable drinking water for all" by 2030.[83] Under Goal 6.2, the target is to "achieve access to adequate and equitable sanitation and hygiene for all and end

---

[76] *Id.*

[77] Leo Heller, Special Rapporteur on the Human Rights to Safe Drinking Water and Sanitation, Statement at the 45th Session of the Human Rights Council, ¶ 2 (Sept. 15, 2020), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/174/68/PDF/G2017468.pdf?OpenElement.

[78] *Id.*

[79] G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development ¶ 7 (Oct. 21, 2015) [hereinafter 2030 Agenda for Sustainable Development].

[80] *Id.* ¶ 26.

[81] *Id.* ¶ 74.

[82] *Goal 6: Ensure access to water and sanitation*, UNITED NATIONS, https://www.un.org/sustainabledevelopment/water-and-sanitation/ (last visited Feb. 11, 2021).

[83] *Id.*

open defecation, paying special attention to the needs of women and girls and those in vulnerable situations" by 2030.[84] As noted by the Special Rapporteur, the SDGs have been criticized because of "the significant margins of discretion given to each State to set their own national targets."[85] He suggested that "the ambitious targets 6.1 and 6.2 of the [SDGs] . . . need to be articulated in conjunction with the obligation to progressively realize human rights."[86]

There are three important components to the idea of progressive realization: (1) the definition of the obligation itself; (2) the concept of "maximum available resources;" and (3) the concept of "minimum core obligations."[87]

1. The Obligation

Ved P. Nanda, director of the Ved Nanda Center for International and Comparative Law at the University of Denver, noted that "by calling for progressive realization rather than immediate implementation, the ICESCR framework creates a stumbling block in enforcing state obligations."[88] In regard to water and sanitation, the obligations that States Parties have under the concept of progressive realization require them to "analyz[e] how [they have] progressed in terms of service provision and what plans are in place."[89]

Progressive realization can proceed by two different strategies: vertical realization, which involves "progressively improving the level of service towards fully meeting the normative content of the human rights to water and sanitation" or horizontal realization, which refers to "progressively moving towards equal enjoyment of the human rights to water and sanitation by target[ing] the unserved and underserved."[90] Under the strategy of vertical realization, progress can be tracked by the "ladders" adopted by WHO and UNICEF's Joint Monitoring Program (JMP) for Water Supply, Sanitation, and Hygiene.[91] The ladder for water and sanitation services is comprised of five rungs: (1) surface water/open defecation; (2) unimproved; (3) limited; (4) basic; and (5) safely managed.[92] The ladder for hygiene, which measures the ability to

---

84 *Id.*

85 Heller, *supra* note 77.

86 *Id.*

87 *See id.*

88 Ved P. Nanda, *The Human Right to Water: Challenges of Implementation*, 50 U. PAC. L. REV. 13, 30 (2018).

89 Heller, *supra* note 77, ¶ 7.

90 *Id.* ¶ 8.

91 *Id.* ¶ 9.

92 *Id.* ¶ 2.

engage in handwashing, has three rungs: (1) no facility; (2) limited; and (3) basic.[93]

The horizontal approach, on the other hand, "more clearly . . . emphasizes human rights principles, including accountability, access to information, participation, prevention, and the right to remedy."[94] Instead of visualizing progress as scaling rungs up a ladder, the horizontal approach is centered around certain baselines that States should take into account when making decisions concerning the right to water and sanitation.[95] The Rapporteur recommended that States should ask the following questions: Are the water and sanitation services actively contributing to reducing inequalities? Have the current water and sanitation services been established with active, free, and meaningful participation? How are the services being monitored? The horizontal approach is consistent with the policy recommendations suggested by Regnér that would make water and sanitation systems more "gender-responsive."[96]

2. Maximum Available Resources

The second important component to understanding progressive realization is the concept of "maximum available resources," which "operates as a qualifier" of how States are fulfilling their obligations.[97] In regard to the human right to water and sanitation, the primary constraining resources are financial.[98] However, resources include both the resources currently available within a State, as well as potential aid from the international community, which means that "where domestic resources are insufficient, it is incumbent on States to seek help from outside sources."[99]

3. Minimum Core Obligations

The third concept fundamental to understanding progressive realization is that of "minimum core obligations," which the Special Rapporteur analogized to "a floor below which the conditions should not be permitted to fall and a house providing feasible structure and an enabling environment for people to enjoy

---

93 *Id.*

94 *Id.* ¶ 14.

95 *Id.* ¶ 10.

96 *See* Åsa Regn. . .r, Deputy Executive Direct of UN Women, Remarks at the World Water Week Celebration (Aug. 28, 2018), https://www.unwomen.org/en/news/stories/2018/8/speed-ded-regner-stockholm-world-water-week.

97 Heller, *supra* note 77, ¶ 18.

98 *Id.* ¶ 19.

99 *Id.* ¶ 24.

entitlements as part of their rights."[100] There is no clear answer to the minimum amount of water individuals are entitled to, as it varies across States.[101] However, the Rapporteur noted that the average amount of water required for human survival "needs to be applied in context."[102] The Rapporteur offered the following questions as guidance to assessing context: "What is the minimum essential amount of water and what is the minimum essential level of sanitation needed for a specific person or group in a specific social, economic and environmental condition to avoid intolerable health risks and provide privacy and dignity? How long does it take individuals to collect the minimum amount of water they need?"[103]

States Parties are required to take action to prevent the spread of disease through WASH services. Working off WHO guidelines for drinking-water quality, States should "identify standards and parameters to regulate water quality, depending on the context and priority in terms of water quality, as well as measures for quality control and surveillance."[104] The Rapporteur recommended the following questions for consideration: "Are there laws and regulations that establish drinking water standards in line with the most recent international guidelines? Is there a government body, within the health sector, with the mandate to comply with water quality surveillance?"[105]

Under the ICESCR, realization of the minimum core obligations is supposed to happen immediately, not progressively.[106] States must take the necessary steps to put into place a national water and sanitation strategy that addresses the entire population, particularly individuals or groups in vulnerable situations.[107] In the Special Rapporteur's analogy, this strategy is the house, which fosters an enabling environment.[108] To ensure that the environment is enabling to all individuals, States must "identify and monitor grounds of discrimination and the underlying causes of discrimination" by assessing disaggregated data.[109]

At the conclusion of his address, the Special Rapporteur acknowledged that "there is a notable absence of clarity" concerning what constitutes the minimum

---

100 *Id.* ¶ 31.
101 *Id.* ¶ 35.
102 *Id.* ¶ 36.
103 *Id.*
104 *Id.* ¶ 42.
105 *Id.* ¶ 43.
106 *Id.* ¶ 44.
107 *Id.*
108 *Id.* ¶ 31.
109 *Id.* ¶ 47.

core obligations of States Parties and what steps States Parties should take to progressively realize the rights to water and sanitation.[110]

D. Monitoring Implementation of the Right to Water

There are various U.N. mechanisms in place to monitor the implementation of the human rights to water and sanitation at the international level, including reviews by treaty bodies, universal periodic reviews, and special procedures.[111] The CESCR monitors the implementation of the obligations of the State Parties to the ICESCR.[112] The committees of other treaty bodies, such as CEDAW and CRC, have assessed progress toward the human rights to water and sanitation in their reviews.[113] Universal periodic reviews are a peer-review mechanism of the HRC that enables Member States to examine other States' human rights records and address human rights violations as they occur.[114] Special procedures of the HRC enable "independent human rights experts with a mandate to report, monitor, and advise on human rights from a country-specific perspective."[115]

As previously mentioned, UN-Water, in partnership with WHO, also publishes an annual Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) report.[116] The report "not only monitors how much funding is committed to water and sanitation by each state and external support agencies, [but] also reveals whether national frameworks incorporate the human rights to water and sanitation with a focus on disadvantaged groups, monitoring, and accountability."[117]

UN-Water's report on how to promote non-discrimination and equality in the context of fulfilling the right to water and sanitation recommends three types of indicators that states should measure: structural indicators, progress indicators, and outcome indicators.[118] Structural indicators, which track the commitments made by States and examine their legislative and policy framework with regards to the principles of non-discrimination and equality, as well as their corresponding affirmative action clauses in furtherance of these principles, can include date of entry into force and coverage of national

---

110 *Id.* ¶ 48.
111 Eliminating Discrimination and Inequalities in Access to Water and Sanitation, *supra* note 64, at 52.
112 *Id.*
113 *Id.* at 12.
114 *Id.* at 52.
115 *Id.*
116 *Id.* at 30.
117 *Id.*
118 *Id.* at 32.

standards for safe drinking water and secure and hygienic sanitation facilities in line with WHO guidelines; time frame and coverage of hygienic awareness programs contained in the national health strategy and educational curricula; and accession to international human rights treaties relevant to the rights to water and sanitation.[119] Process indicators, which measure the impact of these affirmative action clauses and assess whether they "specifically target those excluded and most in need," can include government expenditures on water and sanitation as a proportion of gross national income or total public expenditure; the proportion of received complaints on the rights to water and sanitation investigated and adjudicated by courts or other relevant bodies, as well as the proportion of those complaints responded to effectively by the government; and the proportion of the targeted population reporting satisfaction with how involved they feel in decision making affecting their access to adequate water and sanitation.[120] Finally, outcome indicators, which determine whether a State's targets have ultimately been achieved, can include "number of recorded deaths and incidence of disease (i.e. diarrhea, cholera, arsenic) due to adulterated water source or lack of adequate sanitation;" "proportion of women and adolescent girls that are able to manage menstruation hygienically and with dignity (e.g. privacy for changing and for washing, access to water and soap, disposal facilities)"; and "proportion of household taking more than X minutes round trip time to go to water source, wait for their turn, collect the water, and return home."[121]

II. WASH IN HCFS

A. The Starting Point and Call to Action

In 2015, WHO and UNICEF published a report titled Water, Sanitation and Hygiene in Health Care Facilities: Status in Low- and Middle-Income Countries and Way Forward.[122] This report represented the first joint effort to undertake a global assessment of the extent to which HCFs were able to provide essential WASH services.[123] The report, which drew on data from 54 countries and 66,101 facilities, found that 38 percent of HCFs did not have an improved water source, 19 percent did not have improved sanitation, and 35 percent did not have

119 *Id.* at 50.
120 *Id.* at 51.
121 *Id.*
122 WASH IN HCF: Status in LMIC, *supra* note 10.
123 *Id.* at III.

water and soap for handwashing.[124] The absence of an improved water and sanitation source, as well as a lack of water and soap for handwashing, compromise a HCF's ability to provide basic, routine services such as child delivery.[125]

The report noted the nexus between WASH and maternal and child health, explaining that the provision of WASH services in HCFs serves not only to prevent infections and the spread of disease, particularly among newborns, but also serves to uphold the dignity of vulnerable populations, such as pregnant women.[126] As previously mentioned, while a lack of access to WASH services in HCFs can discourage women from giving birth in these facilities, improving WASH conditions, however, can build trust in HCFs and encourage mothers to seek prenatal care, benefiting both them and their future children.[127]

In 2018, the U.N. Secretary-General spoke at the Launch of the International Decade for Action on Water for Sustainable Development, stating that "quite simply, water is a matter of life and death."[128] He explained that "today, I am using the launch of the Water Action Decade to make a global call to action for [WASH] in all [HCFs]."[129] He set forth the three core objectives of his plan. First, "to transform our silo-based approach to water supply, sanitation, water management and disaster risk reduction to better tackle water stress, combat climate change and enhance resilience."[130] Second, "to align existing water and sanitation programmes and projects with the 2030 [SDGs]."[131] Third, "to generate the political will for strengthened cooperation and partnerships."[132]

B. The World Health Assembly Steps In

In 2019, four years after the first survey report was published in 2015 and one year after the U.N. Secretary General's call to action, WHO's World Health Assembly ("WHA") passed a resolution relating to WASH services in HCFs. In explaining its rationale, the WHA "recall[ed] . . . [GA] resolution 64/292 (2010) on the human right to water and sanitation" and noted:

---

124 *Id.* at IV.

125 *Id.*

126 *Id.* at 1.

127 *Id.*

128 U.N. Secretary General, Remarks at the Launch of International Decade for Action on Water for Sustainable Development (Mar. 22, 2018), https://www.un.org/sg/en/content/sg/statement/2018-03-22/secretary-generals-remarks-launch-international-decade-action-water [hereinafter "Call to Action on WASH in HCF"].

129 *Id.*

130 *Id.*

131 *Id.*

132 *Id.*

> without sufficient and safe water, sanitation, and hygiene services in health care facilities, countries will not achieve the targets set out in [SDG] 3 (ensure healthy lives and well-being for all at all ages) and [SDG] 6 (ensure availability and sustainable management of water and sanitation for all), including reducing maternal and newborn mortality and achieving effective universal health coverage.[133]

The 2019 WHA resolution on Water, Sanitation and Hygiene in Health Care Facilities, in contrast to the 2010 GA resolution on The Human Right to Water and Sanitation, sets out eleven specific actions that WHO Member States can take in order to ensure WASH in HCF, including conducting comprehensive assessments to quantify the availability and quality of, and needs for, WASH in HCF; developing and implementing a national roadmap; setting targets within health policies and integrating WASH indicators into national monitoring mechanisms; integrating WASH into nutrition and maternal, child and newborn health programming; and having procedures and funding in place to operate and maintain WASH services.[134]

The 2019 Global Meeting for WASH in HCFs, which was co-hosted by WHO, UNICEF and the Government of the Republic of Zambia, brought together stakeholders from governments, WHO and UNICEF, NGOs and implementing partners, international organizations, donors, and academia and researchers.[135] By the end of the three-day meeting, several priority areas were identified, including tracking progress and holding countries accountable; building a "movement" on WASH in HCFs that involves the health sector; and securing more investments and high level advocacy among health leaders.[136] WHO and UNICEF, through the Joint Monitoring Programme (JMP), committed to providing an update of the global data in 2020.[137] The participants concluded that "following the [U.N. Secretary General's] Call to Action (2018) and the 2019 WHA resolution, there was consensus that this is an opportune time to build a 'movement' on WASH in [HCFs]."[138] They agreed that the WASH movement should "build on the momentum of health initiatives that resonate in each country or region," such as maternal and newborn health.[139]

---

133 *Id.*

134 *See* The Human Right to Water and Sanitation, *supra* note 20.

135 *See WASH in Healthcare Facilities*: *From Resolution to Revolution*, WHO, at 3 (2019), https://www.who.int/water_sanitation_health/facilities/resolution-tor-revolution-meeting-report-zambia2019.pdf?ua=1.

136 *Id.* at 3–4.

137 *Id.* at 4.

138 *Id.* at 4.

139 *Id.*

In 2020, WHO and UNICEF published a report entitled Global Progress Report on WASH in Healthcare Facilities: Fundamentals First.[140] In the foreword, updated statistics were provided on WASH indicators: one-third of HCFs do not have adequate hygiene facilities for handwashing, one-fourth of HCFs lack basic water services, and one-tenth of HCFs have no sanitation services.[141] Compare this to the data published in 2015: over one-third of HCFs did not have water and soap for handwashing or an improved water source, and almost one-fifth did not have improved sanitation.[142]

Narrowing down the survey pool of the Fundamentals First report to the world's 47 least-developed countries reveals a startling data point: half of HCFs in the least-developed countries lack basic water services.[143] However, there is good news: in response to action steps provided by the 2019 WHA resolution, approximately 85 percent of the 47 countries included in the report have conducted situational analyses, while 65 percent have updated and implemented related standards.[144] Further, 70 percent have set up national coordination mechanisms.[145]

In response to the U.N. Secretary General's 2018 call to action, the following targets were set: (1) by 2025, at least 80 percent of facilities would have basic WASH services, and (2) by 2030, there would be universal access to WASH services.[146] Another target was that by 2021, all countries would have standards, and by 2023, all countries would have included WASH in health plans, budgets, and implementation efforts.[147] As of the report's publication in December 2020, nearly 100 percent of the countries included had drafted or were updating standards and 11 percent of countries had included WASH indicators in health systems monitoring, demonstrating integration through national quality policies and child and maternal health programs.[148]

The report re-lists the global commitments made to WASH in HCFs through WHA Resolution 72.7, which are to be performed by three different types of actors.[149] First, the 194 Member States will (1) conduct assessments on the status

---

140 Fundamentals First, *supra* note 7.
141 *Id.* at iv.
142 WASH IN HCF: Status in LMIC, *supra* note 10, at IV.
143 Fundamentals First, *supra* note 7, at iv.
144 *Id.* at 1.
145 *Id.*
146 *Id.* at 2.
147 *Id.* at 3.
148 *Id*.
149 *Id*. at 7.

of WASH and infection prevention and control; (2) develop and implement national roadmaps; (3) establish and implement minimum standards and integrate into accreditation and regulation systems; (4) include WASH in all health care facility budgets, especially for operation and maintenance; (5) establish strong multisectoral collaboration mechanisms; (6) invest in a sufficient and trained health workforce; (7) focus on facilities with the poorest WASH conditions, where maternal and child health services are provided; and (8) integrate WASH into health programming, including into nutrition and maternal, child and newborn health within the context of safe, quality and integrated people-centered health services.[150] These "eight practical steps" provide a framework by which Member States can take action, as well as a basis for monitoring.[151] They represent a "distillation of 'what works' from over 50 countries" and were "developed through a multi-year, iterative process facilitated by WHO and UNICEF."[152]

Second, international, regional, and local partners will (1) raise the profile of safe WASH and infection prevention control in HCFs, in health strategies and in flexible funding mechanisms; (2) commit to help fill the gap in resource-limited countries by implementing efforts to provide WASH in HCFs; (3) empower communities to participate in the decision-making and reporting concerning more equitable and safe WASH services in HCFs; and (4) provide the technical resources and information to help ensure that safe WASH resources are properly installed and maintained in HCFs.[153]

Last, WHO will (1) provide global leadership and produce technical guidance; (2) along with UNICEF, report on the global status of WASH in HCFs as part of efforts to achieve SDG 6 and integrate WASH and Infection Prevention and Control ("IPC") within effective universal health coverage; (3) catalyze the mobilization of resources and support the development of national business cases for WASH and IPC in HCFs; (4) support safe WASH and basic IPC measures in HCFs in times of crisis and humanitarian emergencies; and (5) report on progress in implementing the resolution to the WHA in 2021 and 2023.[154]

The Fundamentals First report displays a country tracker (current as of October 2020) that presents a "snapshot of progress" from forty-seven

---

150 *Id.*
151 *Id.* at 5.
152 *Id.*
153 *Id.*
154 *Id.*

countries.[155] All countries were invited to submit their progress toward five of the eight practical steps, revealing that 15 percent (or 7 countries) have implemented four of the five steps, while 23 percent (or 11 countries) have fully implemented three steps.[156] The three steps on which countries are making the most progress include: developing and implementing national standards (which 86 percent of countries have done), conducting and establishing baselines (which 85 percent of countries have done) and establishing national coordination mechanisms and developing roadmaps (which 82 percent of countries have done).[157] The step that has achieved the least progress is integrating WASH into national monitoring systems (which only 44 percent of countries have done).[158]

Recall that Nanda explained that "by calling for progressive realization rather than immediate implementation, the ICESCR framework creates a stumbling block in enforcing state obligations."[159] Some of the challenges to the implementation of the right to water that Nanda identified included lack of national plans of actions and the lack of comprehensive monitoring of service levels, as well as a lack of accountability.[160] The second and fifth practical steps laid out in the 2019 WHA Resolution address these challenges by urging States to develop and implement national roadmaps and establish strong multisectoral collaboration mechanisms.[161] By publishing their progress for all to see, WHO and UNICEF hold Member States accountable.

The results are encouraging, with the Fundamentals First report concluding that "progress is happening even in fragile and conflict settings" and that, even though WASH in HCFs is a relatively new area of work for some countries, "the Resolution is proving to be a catalyst for action."[162]

In order to increase global investments and support countries in budgeting for WASH services, UNICEF, with support from WHO, World Bank, Water 2020, and WaterAid, is developing a cost and investment package that will "provide a price tag for meeting basic service standards in the 47 least developed countries."[163] Recall that the data from the 2019 GLAAS report indicates that although over 77 percent of countries have developed cost estimates for the

---

155 *Id.* at 49.
156 *Id.* at 52.
157 *Id.*
158 *Id.* at 53.
159 Nanda, *supra* note 88.
160 *Id.* at 31.
161 Fundamentals First, *supra* note 7, at 7.
162 *Id.* at 49.
163 *Id.* at 63.

implementation of their drinking-water and sanitation plans, less than 15 percent of them have sufficient financing secured to implement their plans.[164] Once again, one notable difference between the WASH in HCFs movement and the efforts to implement the right to water appears to lie in the responsibility and latitude given to states in implementing the right to water.

C. WASH Impact on Maternal and Newborn Health

A 2019 survey of over one million women and girls in 114 countries showed that "of the top demands for quality reproductive and maternal health care, respectful and dignified maternity care was the most cited need, followed by WASH services and facilities."[165] Recall that participation in policymaking concerning maternal health and WASH services is a right, as Article 7(b) of CEDAW guarantees all women the right "to participate in the formulation of government policy and the implementation thereof."[166] Particularly in regard to rural women who live in areas where WASH services are not readily accessible, Article 14 of CEDAW memorializes their right to "participate in the elaboration and implementation of development planning at all levels."[167]

Another recent review of nationally-representative HCFs data from four East African countries (Uganda, Rwanda, Kenya, and Tanzania) found that fewer than 30 percent of delivery rooms had access to water—requiring pregnant women to bring their own water in order to bathe themselves and their babies following birth.[168] The authors of this review, which was published in 2016, stated "as far as we are aware, our results are the first attempt to describe the WATSAN [(water and sanitation)] status of childbirth environments across low and middle-income countries, in both facility and home," which speaks to the relative newness of the approach of jointly addressing maternal health and WASH and the lack of research available to confirm the linkage.[169]

The absence of WASH services "jeopardizes birth attendants' ability to carry out hygiene and relevant infection prevention and control practices."[170] A clean delivery requires (1) clean hands of the birth attendant; (2) clean perineum; (3)

---

164 2019 GLAAS Report, *supra* note 58, at 7.

165 *Id.* at 12.

166 CEDAW, *supra* note 24, at art. 7(b).

167 *Id.* at art. 7(b), 14.

168 Giorgia Gon et. al, *Who Delivers Without Water? A Multi Country Analysis of Water and Sanitation in the Childbirth Environment*, 11 PLOS ONE (2016), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0160572.

169 *Id.*

170 *Id.*

clean birth surface; (4) clean cord preparation and cutting; and (5) appropriate newborn postpartum skin care—all of which cannot be achieved without access to adequate WASH.[171]

Infections associated with unclean birthing practices account for 26 percent of neonatal deaths and 11 percent of maternal mortality—which is more than one million deaths per year that could be largely prevented by proper WASH services.[172] Further, up to 20 percent of women in some African countries get a wound infection after having a caesarean section.[173]

Sepsis, which accounts for 20 percent of all-cause global deaths, disproportionately affects neonates and pregnant or recently pregnant women.[174] Death from sepsis is often related to suboptimal quality of care, including inadequate WASH infrastructure and late diagnosis.[175] If a pregnant woman lives in a country that has a high rate of neonatal mortality, her baby "faces a risk of sepsis-related neonatal mortality 34 times greater than in countries with a low rate of neonatal mortality."[176] It is estimated that more than half of all cases of healthcare associated sepsis could be preventable through safe WASH services and appropriate IPC measures.[177]

WHO and UNICEF launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health ("Quality of Care Network") with the aim of halving maternal and newborn deaths and stillbirths in health facilities by 2022.[178] There are currently eleven participating countries: Bangladesh, Cote d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, the United Republic of Tanzania, and Uganda.[179] The 2020 Fundamentals First report highlights three ways that WASH is critical to the achievement of this goal.[180] First, WASH is one of eight core standards of which the Quality of Care Network recommends implementation.[181] Second, WASH can be addressed through quality

---

171 *Id.*

172 Fundamentals First, *supra* note 7, at 9.

173 *Id.*

174 *Id.* at 10.

175 *Id.*

176 Water, sanitation and hygiene in health care facilities: practical steps to achieve universal access, WHO, 1 (2019), HTTPS://APPS.WHO.INT/IRIS/BITSTREAM/HANDLE/10665/311618/9789241515511-ENG.PDF?SEQUENCE=1&ISALLOWED=Y.

177 Fundamentals first, *supra* note 7, at 10.

178 A NETWORK FOR IMPROVING QUALITY OF CARE FOR MATERNAL, NEWBORN AND CHILD HEALTH, https://www.qualityofcarenetwork.org/about (last visited Jan. 17, 2020).

179 *Id.*

180 Fundamentals First, *supra* note 7, at 41.

181 *Id.*

improvement interventions, such as ensuring that functioning WASH facilities are available in the childbirth room and that midwives are educated on the importance of WASH.[182] Third, WASH indicators should be tracked in the country's national information system.[183]

CONCLUSION

In 2015, while reviewing progress toward the Millennium Development Goals, WHO published a commentary entitled Quality of Care for Pregnant Women and Newborns—the WHO Vision.[184] The paper noted that "despite significant progress in reduction of mortality, we still have unacceptably high numbers of maternal and newborn deaths globally."[185] Over the past decade, efforts at decreasing mortality had been focused on increasing skilled birth attendants, resulting in higher rates of births in health facilities.[186] However, what if the HCFs lacked essential resources, such as WASH services? WHO recognized this issue, explaining that "with increasing utilization of health services, a higher proportion of avoidable maternal and perinatal mortality and morbidity have moved to health facilities . . . [making] poor quality of care in many facilities . . . a paramount roadblock in our quest to end preventable mortality and morbidity."[187]

Not only is quality of care considered "a key component of the right to health, [but] the route to equity and dignity for women and children."[188] Recall that in 2002, the CESCR identified the right to water as "a prerequisite for the realization of other human rights," such as the right to health.[189] When it affirmed the GA Resolution on the Human Right to Water and Sanitation, the HRC noted that:

> the human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to

---

182 *Id.*

183 *Id.* at 42.

184 *See* O Tuncalp et. al, *Quality of Care for Pregnant Women and Newborns—the WHO Vision,* 122 BJOG 1045 (2015), https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.13451. The Millennium Development Goals ended in 2015 and preceded the SDGs.

185 *Id.*

186 *Id.*

187 *Id.*

188 *Id.* at 1046.

189 The Human Right to Water and Sanitation, *supra* note 20.

> the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity.[190]

One might wonder how advocating for WASH in HCFs can inspire progress toward achieving the universal right to water outside of HCFs. When considered in the context of improving maternal and child health, access to WASH can and should extend beyond just the four walls of a hospital.

First, pregnant women are more susceptible to water-related diseases which they are exposed to through private water consumption.[191] For instance, exposure to mercury, potassium, and lead is associated with spontaneous abortion and congenital malformations.[192] Pregnant women are also more susceptible to diseases transmitted by insect vectors that may be present at water sources.[193] Systematic studies of malaria prevention efforts reveal significant reductions in severe maternal anemia, as well as low birthweight, perinatal mortality, and stillbirth.[194] As the second Special Rapporteur recommended, even if a State has quality control standards for water in place, the State should take into account different thresholds of exposure for vulnerable groups, such as pregnant women.[195] This is consistent with the conclusion of the researchers from the London School of Tropical Medicine and Hygiene and BRAC who concluded that while major research gaps exist concerning the connection between poor WASH and adverse maternal and neonatal health outcomes, "the evidence strongly suggests that poor WASH influences maternal and reproductive health outcomes to the extent that it should be considered in global and national strategies."[196]

Second, as previously explained, the risk of child death is higher when adults in the household must leave children unsupervised while they go and fetch water.[197] When children collect water, there are increased odds of them developing a diarrheal disease.[198] Reducing childhood mortality was one of the overall aims of the GA in passing The Right to Water and Sanitation, as it expressed it was "deeply concerned that approximately 1.5 million children

---

190 Human Rights and Access to Safe Drinking Water and Sanitation, *supra* note 22.
191 Campbell, *supra* note 13, at 255.
192 *Id.*
193 *Id.* at 257.
194 *Id.* at 256.
195 Rep. of the Special Rapporteur, *supra* note 30, ¶ 33.
196 Campbell, *supra* note 13.
197 Geere, *supra* note 27, at 239.
198 *Id*.

under age 5 die . . . each year as a result of water-and sanitation-related diseases."[199]

The WASH in HCFs movement was able to achieve what the right to water movement could not—the creation of eight practical action steps for Member States to complete, with biennial reporting requirements in order to ensure compliance.[200] Recall that in its 2020 progress report on WASH in HCFs, WHO listed many reasons why WASH in HCFs is a non-negotiable, with two key reasons being that (1) it is a human rights, dignity, gender, and social justice issue; and (2) it is a top priority of women receiving maternal care.[201] Also recall that the right to water contains an entitlement that all individuals have "the right to a system of water supply and management that provides equality of opportunity for people to enjoy the right to water."[202]

If the implementation of WASH services in HCFs is framed as an effort to improve maternal and child health outcomes, it only follows that successes from this movement should serve as a bridge to inspire progress toward universal access to WASH in the home. Further, it is a self-reinforcing circle of sorts, as research suggests that with an improved water supply source within the home, women would have a greater opportunity to "ask for and receive social support in the prenatal period, which could then facilitate her access to antenatal care, or to travel and give birth in a HCF."[203]

---

199 The Human Right to Water and Sanitation, *supra* note 20.

200 Fundamentals First, *supra* note 7

201 *Id.* at 9.

202 General Comment No. 15, *supra* note 15, ¶ 10.

203 Geere, *supra* note 27, at 239.