

Advance Edited Version

Distr.
GENERAL

A/HRC/14/39
16 April 2010

Original: ENGLISH

HUMAN RIGHTS COUNCIL
Fourteenth session
Agenda items 2 and 3

**ANNUAL REPORT OF THE UNITED NATIONS HIGH COMMISSIONER
FOR HUMAN RIGHTS AND REPORTS OF THE OFFICE OF THE
HIGH COMMISSIONER AND THE SECRETARY-GENERAL**

**PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS,
CIVIL, POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS,
INCLUDING THE RIGHT TO DEVELOPMENT**

**Report of the Office of the United Nations High Commissioner for Human Rights on
preventable maternal mortality and morbidity and human rights***

Summary

The present study is submitted pursuant to Human Rights Council resolution 11/8. It identifies the human rights dimensions of preventable maternal mortality and morbidity in the existing international legal framework. It also includes an overview of initiatives and activities within the United Nations system to address causes of preventable maternal mortality and morbidity and identifies how the Council can add value to existing initiatives through a human rights analysis.

* Late submission.

CONTENTS

	<i>Paragraphs</i>	<i>Page</i>
I. INTRODUCTION	1-3	
II. MATERNAL MORTALITY AND MORBIDITY: DEFINITION AND SCALE	4-7	
III. HUMAN RIGHTS DIMENSIONS OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY AND EXISTING INTERNATIONAL LEGAL FRAMEWORK	8-44	
A. Equality and non-discrimination	14-21	
B. Rights in focus: the right to life, the right to health and the right to education and information	22-31	
C. Human rights-based approach to maternal mortality and morbidity.....	32-44	
IV. OVERVIEW OF INITIATIVES AND ACTIVITIES WITHIN THE UNITED NATIONS SYSTEM AND BEYOND TO ADDRESS ALL CAUSES OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY	45-57	
A. Normative and policy development.....	46-49	
B. Services	50-56	
C. Accountability	57	
V. CONCLUSIONS AND RECOMMENDATIONS	58-65	

I. INTRODUCTION

1. The present report is submitted to the Human Rights Council pursuant to resolution 11/8, in which the Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to prepare a thematic study on preventable maternal mortality and morbidity and human rights, in consultation with States, the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Bank, and all other relevant stakeholders. For the purpose of informing the content of the report, a note verbale was sent to States, United Nations agencies and non-governmental organizations on 1 October 2009 soliciting information and observations. Written contributions were received from 28 States,¹ one observer State,² nine United Nations entities and inter-governmental agencies,³ and 22 non-governmental organizations, coalitions and other groups.⁴ All submissions may be viewed on the OHCHR website.⁵

2. In chapter II of the report, OHCHR provides a short introduction to the definition and scale of maternal mortality and morbidity. In chapter III, the human rights dimensions of preventable maternal mortality and morbidity are identified, with reference to the relevant existing international and regional legal framework, including the jurisprudence, general

¹ Australia, Azerbaijan, Bahrain, Belarus, Bulgaria, Canada, Chile, Costa Rica, Egypt, El Salvador, Estonia, Finland, Germany, Hungary, Kazakhstan, Latvia, Madagascar, New Zealand, Norway, Pakistan, Philippines, Saudi Arabia, Serbia, Slovakia, Spain, Switzerland, Syrian Arab Republic and Ukraine.

² The Holy See.

³ Food and Agriculture Organization of the United Nations (FAO), International Atomic Energy Agency (IAEA), International Labour Organization (ILO), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children Fund (UNICEF), World Food Programme (WFP) and World Health Organisation (WHO).

⁴ Action Canada for Population and Development; American Association of Pro-Life Obstetricians and Gynecologists; Amnesty International; Catholic Family and Human Rights Institute; Center for Reproductive Rights; Cercle de recherche sur les droits et les devoirs de la personne humaine; Doha International Institute for Family Studies and Development; Egyptian Initiative for Personal Rights; Federation for Women and Family Planning-Poland; Human Rights Watch; International Commission of Jurists; International Disability Alliance and its Convention on the Rights of Persons with Disabilities Forum; International Initiative on Maternal Mortality and Human Rights (consisting of 13 civil society organizations: Averting Maternal Death and Disability Program at Columbia University (United States of America), CARE (global), the Center for Justice and International Law (United States and Latin America), the Center for Reproductive Rights (United States), Equinet Regional Network on Equity in Health in Southern Africa (South Africa), Family Care International (United States), the Health Equity Group (Tanzania), the Human Rights Centre at the University of Essex (United Kingdom of Great Britain and Northern Ireland), the International Budget Partnership (Mexico), the Kvinna till Kvinna Foundation (Sweden), Likhaan (Philippines), Physicians for Human Rights (United States), and SAHAYOG (India); International Planned Parenthood Federation; IPAS; IPAS-Brazil; Minnesota Citizens Concerned for Life Global Outreach; Red Nacional Feminista de Salud, Derechos Sexuales y Derechos Reproductivos; Netherlands network on sexual and reproductive health and aids (Share-net); Society for the Protection of Unborn Children; The Prolife Center at the University of St. Thomas School of Law-Minnesota; Youth Coalition for Sexual and Reproductive Rights.

⁵ <http://www2.ohchr.org/english/issues/women/documentation.htm>.

comments and recommendations, and concluding observations of the human rights treaty monitoring bodies and judicial and quasi-judicial bodies. In chapter IV, OHCHR provides an overview of initiatives and activities within the United Nations system that address issues of preventable maternal mortality and morbidity. Finally, in chapter V, it identifies how the Council can add value to existing initiatives through a human rights analysis, including efforts to achieve the Millennium Development Goal on improving maternal health, and recommends options for better addressing the human rights dimensions of preventable maternal mortality and morbidity throughout the United Nations system.

3. Reports prepared ahead of the forthcoming review at the High-level Plenary Meeting of the General Assembly in September 2010 (the Millennium Development Goals Summit) indicate that of all the Goals, Goal 5 on improving maternal health, with its related targets on reducing the maternal mortality ratio by three quarters by 2015 and achieving universal access to reproductive health, is the furthest from being achieved.⁶ Human Rights Council resolution 11/8 could thus not have been more timely in acknowledging that preventable maternal mortality and morbidity is a human rights issue and challenge that needs increased attention.

II. MATERNAL MORTALITY AND MORBIDITY: DEFINITION AND SCALE

4. WHO defines maternal mortality as: “the death of a woman while pregnant or within 42 days of termination of pregnancy ... from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”.⁷ In turn, maternal morbidity is defined as “a condition outside of normal pregnancy, labour, and childbirth that negatively affects a woman’s health during those times”.⁸

5. Although standardized definitions of maternal mortality and its causes exist, it is difficult to accurately measure levels of maternal mortality for three primary reasons: (a) it is challenging

⁶ Thoraya Ahmed Obaid (UNFPA), “Successful strategies for women’s health and rights: achieving MDG 5”, keynote address to the Swedish International Development Agency, 22 May 2008; Margaret Chan (WHO), “Opening remarks at the roundtable with women leaders on MDG5”, 25 September 2008, available from www.who.int/making_pregnancy_safer/events/2008/mdg5/speech/en/index.html. See also *The Millennium Development Goals Report 2009* (United Nations publication, Sales No. E.09.I.12), p. 27.

⁷ WHO, *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, vol. 2, *Instruction Manual*, 2nd ed. (Geneva, 2004), p. 141.

⁸ S.A. Orshan, *Maternity, Newborn and Women’s Health Nursing: Comprehensive Care across the Life Span* (Philadelphia, Lippincott Williams and Wilkins, 2008), p. 15.

to identify maternal deaths; (b) the woman's pregnancy status may not be known; and (c) in country settings where medical certification of cause of death does not exist, accurate attribution of female deaths as maternal death is difficult.⁹ While updating of statistics is a time-consuming exercise, new global statistics are currently being prepared in the context of the upcoming 2010 Millennium Development Goals Summit to measure international efforts towards achieving the Goals, including on improving maternal health. Pending this, according to the most recent official estimates over half a million maternal deaths occur worldwide each year. This translates into an adult lifetime risk of maternal death (the probability that a 15-year-old female will die eventually from a maternal cause) of 1 in 92 for women worldwide.¹⁰ In some countries, this risk of maternal death is as high as 1 in 7.¹¹ Meanwhile for every maternal death, an estimated 20 women suffer pregnancy-related injury, infection or disease, i.e. approximately 10 million women. In some cases, long-term disabilities (such as prolapse, infertility, obstetric fistula or incontinence) can result.¹² For several reasons, pregnancy and childbirth imply higher risks for young adolescents. In developing countries, complications of pregnancy and childbirth are the leading causes of death among girls and women between 15 and 19 years old, with 15 per cent of total maternal deaths worldwide occurring among adolescents.¹³

6. Five types of obstetric emergencies account for most maternal deaths: haemorrhage (25 per cent); infection/sepsis (15 per cent); unsafe abortion (13 per cent); pre-eclampsia and eclampsia (12 per cent); and prolonged or obstructed labour (8 per cent).¹⁴ According to WHO, UNICEF, the World Bank and other stakeholders, the majority of maternal deaths and disabilities could be prevented through access to sufficient care during pregnancy and delivery and effective interventions. This affirmation is supported by the observation that in some countries maternal mortality has been virtually eliminated. Only 15 per cent of pregnancies and childbirths need emergency obstetric care because of complications that are difficult to predict.¹⁵

⁹ WHO, *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank* (Geneva, 2007), p. 5; see also pp. 1-2.

¹⁰ *Ibid.*, p. 16.

¹¹ *Ibid.*, p. 1.

¹² G. Naanda, K. Switlick and E. Lule, *Accelerating Progress towards Achieving the MDG to Improve Maternal Health: A Collection of Promising Approaches* (Washington, DC, World Bank, 2005), p. 4.

¹³ WHO, *Women and Health: Today's Evidence, Tomorrow's Agenda* (Geneva, 2009), p. 31.

¹⁴ UNFPA, response to the note verbale, p. 2.

¹⁵ www.unicef.org/mdg/maternal.html.

WHO estimates that 88 to 98 per cent of maternal deaths are preventable.¹⁶ More recently, UNICEF has reaffirmed that approximately 80 per cent of maternal deaths could be averted if women had access to essential maternity and basic health-care services.¹⁷ World Bank estimates show that 74 per cent of maternal deaths could be prevented with increased coverage of professionally delivered interventions, especially access to essential obstetric care, access to safe abortion services, active rather than expectant management in the third stage of labour, and the use of anticonvulsants for women with pre-eclampsia.¹⁸ However, the maternal mortality ratio (the number of maternal deaths per 100,000 live births) declined globally at a rate of less than 1 per cent a year between 1990 and 2005.¹⁹ The estimated total number of women dying in pregnancy or childbirth per year decreased only slightly between 1990 and 2005 (from 576,000 deaths in 1990 to 536,000 deaths in 2005).²⁰

7. There are large disparities in maternal mortality rates between and within States. Although the majority of maternal deaths occur in developing States, mainly in Africa and South Asia,²¹ when maternal mortality and morbidity data in developed States are disaggregated, they reveal rates that vary dramatically between different ethnic and socio-economic communities. Governments in developed States have binding human rights obligations to take measures to address this de facto discrimination. Already in 2001 a report by WHO recognized that “the failure to address preventable maternal disability and death represents one of the greatest social injustices of our times”²² and that “women’s reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather, injustices that societies are able and obligated to remedy”.²³

III. HUMAN RIGHTS DIMENSIONS OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY AND EXISTING INTERNATIONAL LEGAL FRAMEWORK

¹⁶ WHO, “Maternal mortality: helping women off the road to death”, *WHO Chronicle*, vol. 40 (1986), pp. 175-183.

¹⁷ UNICEF, *The State of the World’s Children 2009: Maternal and Newborn Health* (United Nations publication, Sales No. E.09.XX.1), p. 2.

¹⁸ A. Wagstaff and M. Claeson, *The Millennium Development Goals for Health: Rising to the Challenges* (Washington, DC, World Bank, 2004), pp. xi, 6, 51 and 52.

¹⁹ WHO, *Maternal Mortality in 2005*, p. 2.

²⁰ *Ibid.*, p. 17.

²¹ *Ibid.*, p. 15.

²² R.J. Cook, B.M. Dickens and others, *Advancing Safe Motherhood through Human Rights* (Geneva, WHO, 2001), p. 5.

²³ *Ibid.*, p. 69.

8. There has been an increasing understanding at the international and regional levels that reducing maternal mortality and morbidity is not solely an issue of development, but a matter of human rights.²⁴ In its resolution 11/8 (para. 2), the Human Rights Council identifies a range of human rights directly implicated by maternal mortality and morbidity, namely, 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”. International human rights treaties and the general comments, recommendations and concluding observations of several treaty bodies have recognized that maternal mortality implicates a wider range of human rights and have recommended that States parties take effective measures to reduce maternal mortality rates and improve maternal health,²⁵ with reference to, inter alia, the right to be free from cruel, inhumane and degrading treatment, the right to privacy and the right to an effective remedy. These rights are enshrined in various international and regional human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the Convention on the Elimination of All Forms of Discrimination against Women.

²⁴ See for example African Commission on Human and Peoples’ Rights, ACHPR/Res. 135 (XXXXVIII), resolution on maternal mortality in Africa (2008); and European Parliament, resolution on maternal mortality ahead of the UN High-level Event, 25 September – review of the Millennium Development Goals (2008).

²⁵ See for example: concluding observations of the Committee on the Elimination of Discrimination against Women: Algeria (A/60/38), para. 131; Czech Republic (A/57/38), para. 85; India (CEDAW/C/IND/CO/3), para. 40; Saint Kitts and Nevis (A/57/38), para. 88; Sri Lanka (A/57/38), para. 217; Turkey (CEDAW/C/TUR/CC/4-5), para. 38; concluding observations of the Human Rights Committee: Bolivia (CCPR/C/79/Add.74), para. 22; Libyan Arab Jamahiriya (CCPR/C/79/Add.101), para. 9; Mongolia (CCPR/C/79/Add.120), para. 8(b); Paraguay (A/51/38), para. 123; Senegal (CCPR/C/79/Add.82), para. 12; concluding observations of the Committee on the Elimination of Racial Discrimination (CERD): Benin (E/C.12/BEN/CO/2), para. 25; Brazil (E/C.12/1/Add.87), para. 27; China (E/C.12/1/Add.107), para. 36; Democratic People’s Republic of Korea (E/C.12/1/Add.95), para. 23; Mexico (E/C.12/MEX/CO/4), para. 25; Morocco (E/C.12/MAR/CO/3), para. 13(f); Paraguay (E/C.12/PRY/CO/3), para. 21; Poland (E/C.12/1/Add.82), para. 29; Senegal (E/C.12/1/Add.62), para. 26; concluding observations of the Committee on the Rights of the Child: Argentina (CRC/C/15/Add.187), para. 46; Azerbaijan (CRC/C/AZE/CO/2), para. 49(b); Benin (CRC/C/BEN/CO/2), para. 51; Botswana (CRC/C/15/Add.242), para. 48; Colombia (CRC/C/COL/CO/3), para. 68(b); Philippines (CRC/C/PHL/CO/3-4), para. 55; Yemen (CRC/C/15/Add.128), para. 55(c). For a comprehensive review of concluding observations and general comments and recommendations of treaty bodies on maternal mortality see: Center for Reproductive Rights, “Bringing rights to bear: preventing maternal mortality and ensuring safe pregnancy” (2008).

9. Maternal mortality is overwhelmingly due to a number of interrelated reasons, or delays, which ultimately prevent pregnant women from accessing the health care they need.²⁶ These delays, often referred to as the “three delays”, are understood to encompass: (a) delay in seeking appropriate medical help for an obstetric emergency for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality; (b) delay in reaching an appropriate facility for reasons of distance, infrastructure and transport, and; (c) delay in receiving adequate care when a facility is reached because there are shortages in staff, or because electricity, water or medical supplies are not available.²⁷ When examining the elements of these three delays from a human rights perspective, numerous rights are at play and, consequently, a range of States’ human rights responsibilities may be engaged.

10. When women die in pregnancy or childbirth because the Government fails to use its available resources to take measures necessary to address the preventable causes of maternal death and ensure availability, accessibility, acceptability and good quality of services, the responsibility of the State may be engaged in respect of a violation of women’s right to life. Preventable maternal deaths and injuries may also entail violations of the right to the highest attainable standard of physical and mental health, including sexual and reproductive health, the rights to equality and to non-discrimination and the rights to information, to education and to enjoy the benefits of scientific progress. These rights cannot be seen as absolutely distinct but rather as “indivisible, interdependent, interrelated, and of equal importance for human dignity”.²⁸

11. States are obligated under international human rights law to respect, protect and fulfil human rights in relation to surviving pregnancy and childbirth. These human rights obligations are not only valid in and of themselves, the analysis they foster also contributes to identifying obstacles to more effective public health interventions to eliminate maternal mortality and morbidity.

²⁶ D. Maine, *Safe Motherhood Programs: Options and Issues* (New York, Columbia University, 1991); UNFPA response to the note verbale, p. 2; report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/61/338), para. 21.

²⁷ UNFPA, response to the note verbale, p. 2; A/61/338, para. 21.

²⁸ Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1997), para. 4. See also: Universal Declaration of Human Rights; Vienna Declaration and Programme of Action (1993), para. 5;.

12. In the context of preventable maternal mortality and morbidity, these obligations require States (a) to refrain from taking actions that would obstruct women's access to the health-care services they need or to the underlying determinants of health²⁹ (duty to respect), (b) to take measures to prevent women from dying in childbirth and pregnancy (duty to protect) and (c) to take legislative, administrative, and judicial action, including through the commitment of maximum available resources to prevent maternal mortality and morbidity (duty to fulfil). Therefore, States' human rights obligations include both negative obligations to refrain from action, and positive obligations to act affirmatively to prevent maternal mortality and morbidity, including by taking steps to ensure women can access maternal health care and other relevant sexual and reproductive health services.

13. International human rights treaties and their interpretation by human rights bodies have made clear that many of the obligations States must undertake to prevent maternal mortality and morbidity are of immediate effect. While ICESCR recognizes that many of the rights it guarantees are subject to progressive realization, and requires States to take steps to achieve those rights to the maximum of their available resources, the Covenant also imposes certain core obligations that are of immediate effect. The Committee on Economic, Social and Cultural Rights (CESCR) has emphasized that "a State Party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations ... which are non-derogable".³⁰ CESCR has stated that the provision of maternal health services is comparable to a core obligation, and that States have the immediate obligation to take "deliberate, concrete and targeted steps" towards fulfilling the right to health in the context of pregnancy and childbirth.³¹ The Convention on the Elimination of All Forms of Discrimination against Women also establishes that State obligations to address maternal mortality and morbidity are of immediate effect. It requires State parties to ensure services for maternal health and equality in access to health services (art. 12), as denying services that only women need is a form of discrimination.³²

²⁹ On the "underlying determinants of health", see A/61/338, para. 18.

³⁰ CESCR, general comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 47.

³¹ *Ibid.*, paras. 30, 43 and 44(a).

³² Committee on the Elimination of Discrimination against Women (CEDAW), general recommendation No. 24: Women and health (art. 12) (1999), para. 11.

Moreover, the right to life and other civil and political rights, and the right to non-discrimination, are not subject to progressive realization.³³

A. Equality and non-discrimination

14. The scale of maternal mortality and morbidity across the world reflects a situation of inequality and discrimination³⁴ suffered by women throughout their lifetimes, perpetuated by formal laws, policies and harmful social norms and practices. An approach to preventable maternal mortality and morbidity that applies the human rights principles of equality and non-discrimination will provide stakeholders, including States, international organizations, and members of both the human rights and public health communities, with a vital tool in their ongoing efforts to address the problem. It can facilitate the identification of high-risk groups, enable analysis of the complex gaps in protection, participation and accountability they are facing, and promote the identification of comprehensive and sustainable solutions.

1. Obligations under international human rights law

15. International human rights law specifies that all human beings must be able to enjoy and exercise their human rights on a basis of equality between women and men,³⁵ and free from discrimination on the basis of sex, race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status.³⁶ Among other things, these fundamental legal requirements oblige States to refrain from discriminatory actions,³⁷ to take positive proactive steps to guarantee equality³⁸ (not just in law, but in policy and practice),³⁹ to ensure

³³ Human Rights Committee, general comment No. 6: Article 6 (right to life) (1982), para. 5; CESCR, general comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2) (2009), para. 7.

³⁴ A/61/338, para. 10; European Parliament, resolution on maternal mortality.

³⁵ ICCPR, art. 3; ICESCR, art. 3; Convention on the Elimination of All Forms of Discrimination against Women, arts. 1 and 2; Human Rights Committee, general comment No. 28; CESCR, general comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3) (2005); CESCR, general comment No. 20.

³⁶ ICCPR, art. 2, para. 1; ICESCR, art. 2, para. 2; Convention on the Rights of the Child, art. 2, para. 1; Human Rights Committee, general comment No. 18: Non-discrimination (1989); CESCR, general comment No. 20.

³⁷ CESCR, general comment No. 16, para. 18.

³⁸ *Ibid.*, para. 21; CESCR, general comment No. 20, para. 8(b); CEDAW, general recommendation No. 25: Temporary special measures (article 4, paragraph 1) (2004), paras. 7-8.

³⁹ CESCR, general comment No. 16, paras. 6-8; CESCR, general comment No. 20, para. 8; CEDAW, general recommendation No. 25, paras. 4-10.

that seemingly neutral measures and approaches do not have a discriminatory effect in real terms,⁴⁰ and in certain contexts to actively recognize and take account of difference.⁴¹

2. Application in the context of preventable maternal mortality and morbidity

16. There are a number of ways in which non-discrimination and equality-related obligations come into play in the context of efforts to prevent women's death and disability from pregnancy-related causes.

Ensuring gender equality and non-discrimination on the basis of sex

17. As research indicates, preventable maternal mortality and morbidity is related to a lack of provision and prioritization of health care⁴² that only women need due to the fact that reproduction takes place in their bodies. Though all human beings are affected in significant ways by preventable maternal mortality and morbidity, by definition it is the lives and health of women and adolescent girls that are directly and immediately impacted. But while interventions and services needed to combat maternal mortality do exist, "there is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal mortality".⁴³ To ensure gender equality and non-discrimination on the basis of sex, States must address this. Specifically, States are obligated to ensure that their laws, policies and practices meaningfully address the specific needs of women due to their ability to become pregnant and give birth.⁴⁴ This includes, among other things, an obligation to ensure women's access to emergency obstetric care and to other sexual and reproductive health information and services, such as family planning.⁴⁵

18. Obligations related to equality and non-discrimination on the basis of sex also explicitly request States to confront a number of underlying factors that contribute to preventable maternal mortality and morbidity. For example, States should take measures to effectively reduce and

⁴⁰ CEDAW, general recommendation No. 25, para. 7; CESCR, general comment No. 16, paras. 5, 12-13; CESCR, general comment No. 20, para. 10.

⁴¹ CEDAW, general recommendation No. 25, para. 8.

⁴² UNICEF, *State of the World's Children 2009*, p. 2.

⁴³ A/61/338, para. 9.

⁴⁴ ICESCR, art. 12, para. 2(a); Convention on the Elimination of All Forms of Discrimination against Women, art. 12, para. 2; CESCR, general comment No. 14, paras. 14, 21 and 44(a); CEDAW, general recommendation No. 24, paras. 26-27.

⁴⁵ CEDAW, general recommendation No. 24, para. 27; CESCR, general comment No. 14, para. 14.

ultimately eliminate gender-based violence and other harmful practices against women and girls,⁴⁶ which exacerbate the risks of a woman's death or disability as a result of pregnancy-related causes.⁴⁷ Action is also required to eliminate other forms of discrimination on the basis of sex that may occur in practice at the local level and in the private sphere,⁴⁸ for example, limits on women's access to nutrition and food, clean water and sanitation, and education, limits which in turn can increase risks of preventable maternal mortality and morbidity.⁴⁹

Non-discrimination on other grounds: addressing intersectional and multiple forms of discrimination

19. Specific groups of women face higher levels of risk of preventable maternal mortality and morbidity. The risk of death or injury due to pregnancy-related causes can depend upon various grounds, including race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status.⁵⁰ Where a person faces discrimination on the basis of more than one of the prohibited grounds (i.e. on the basis of sex and another ground), they are facing cumulative, multiple or intersectional discrimination, which can have a substantially heightened effect on their ability to exercise and enjoy their human rights.⁵¹

⁴⁶ General Assembly resolution 48/104 on the Declaration on the Elimination of Violence against Women, art. 4(c); CEDAW, general recommendation, No. 19: Violence against women (1992); CESCR, general comment No. 14, para. 21. See also: Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Bélem do Pará), art. 7; Inter-American Court of Human Rights, *Case of González and Others (Campo Algodonero) vs. Mexico*, 16 November 2009; European Court of Human Rights, *Case of Opuz vs. Turkey*, judgment of 9 June 2009, application No. 33401/02.

⁴⁷ UN Millennium Project 2005, *Taking Action: Achieving Gender Equality and Empowering Women* (London, Task Force on Education and Gender Equality, 2005), chapter 9. See also: WHO, *Eliminating Female Genital Mutilation: An Interagency Statement (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO)* (Geneva, 2008), p. 11.

⁴⁸ Convention on the Elimination of All Forms of Discrimination against Women, art. 2(d); CESCR, general comment No. 20, para. 11; Human Rights Committee, general comment No. 31: The nature of the general legal obligation imposed on States parties to the Covenant (2004), para. 8.

⁴⁹ UN Millennium Project 2005, *Taking Action*, p. 56.

⁵⁰ Human Rights Committee, general comment No. 18, para. 1, and general comment No. 28, para. 30; CESCR, general comment No. 16, para. 5, and general comment No. 20, paras. 18-35; CEDAW, general recommendation No. 24, para. 26, and general recommendation No. 25, para. 12.

⁵¹ CEDAW, general recommendation No. 25, para. 12; CESCR, general comment No. 16, para. 5, and general comment No. 20, para. 17; Human Rights Committee, general comment No. 28, para. 30; CERD, general comment No. 25: Gender-related dimensions of racial discrimination (2000), para. 1; Durban Declaration (preamble, para. 69) and Programme of Action (paras. 18, 31, 50, 54(a), 176), adopted at the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, 2001.

20. The elevated risk that a woman may face due to multiple discriminations is often tied to a heightened inability to access adequate health care systems and timely interventions and services, although the reasons for this inability may differ. For example, laws or social practices may place age limits, or restrictions related to marital status, on access to sexual and reproductive health care, services and information. Meanwhile for reasons of distance, cost and lack of information or lack of cultural sensitivity, women living in rural areas, indigenous women⁵², displaced persons/refugees, girls, or women of lower social and economic status may not have sufficient access to antenatal services, emergency obstetric care and skilled birth attendants. Furthermore, they may be reluctant to access health care because of language barriers or insensitivity to indigenous practices and traditions. The risk of death and disability from pregnancy-related causes increases even further for women who fall into more than one such category.

21. The human rights requirements of equality and non-discrimination require States to ensure that the steps they take to give effect to the human rights of women and address the specific needs of women are meaningful to all women in society. These human rights further require measures that enable relevant stakeholders to identify and address the reasons behind certain women's heightened inability to access adequate and timely health care interventions and services. Such measures include monitoring and assessment on the basis of disaggregated data, policy assessment and review, and legal reform as appropriate.

B. Rights in focus: the right to life, the right to health and the right to education and information

1. Right to life

22. International and regional guarantees of the right to life require States to take measures to protect individuals from arbitrary and preventable loss of life.⁵³ The number of preventable maternal deaths suggests a systematic failure to provide services needed by women to survive

⁵² Report of the Special Rapporteur on the right to health (A/59/422), para. 55; A/61/338, para. 7; *Official Records of the Economic and Social Council, 2006, Supplement No. 23 (E/2006/43-E/C.19/2006/11)*, paras. 48-49.

⁵³ Human Rights Committee, general comment No. 6, para. 5. See also European Commission on Human Rights, *Tavares v. France*, decision of 12 Sept 1991, application No. 16593/90, , where the Commission found that article 2 of the European Convention on Human Rights means not only that the State has to abstain from intentional killing, but also that it must take the necessary measures to protect life.

childbirth, which may constitute a violation of the right to life. Various human rights bodies have recognized the obligation of States to protect women's right to life in the context of pregnancy and childbirth, with the Human Rights Committee, the Committee on the Elimination of Discrimination against Women (CEDAW) and the African Commission on Human and Peoples' Rights characterizing preventable maternal mortality as a violation of women's right to life.⁵⁴ Several treaty bodies have more specifically underlined the link between unsafe abortion and high rates of maternal mortality and have asked States to ensure that women are not forced to undergo clandestine abortion that endanger their lives.⁵⁵

23. In the context of preventable maternal mortality and morbidity, the right to life is closely connected to the human rights to health, education and information, and equality in the exercise and enjoyment of all human rights. The ability of women to survive pregnancy and childbirth is contingent upon their access to quality reproductive and maternal health care, freedom from social, cultural, economic and legal discrimination, and autonomy over decisions relating to their reproductive lives.

2. Right to the highest attainable standard of physical and mental health

24. The right to health, including sexual and reproductive health, encompasses both the freedom to control one's health and body as well as the right to enjoy a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.⁵⁶

⁵⁴ African Commission on Human and Peoples' Rights, resolution on maternal mortality in Africa; Human Rights Committee, general comment No. 28, para. 10. See also for example: Human Rights Committee concluding observations: Hungary (CCPR/CO/74/HUN), para. 11; Mali (CCPR/CO/77/MLI), para. 14; Zambia, (CCPR/C/ZMB/CO/3), para. 18; CEDAW concluding observations: Madagascar (A/49/38), para. 244.

⁵⁵ See for example: Human Rights Committee concluding observations: Chile (CCPR/C/79/Add.104), para. 15; Guatemala (CCPR/CO/72/GTM), para. 19; Ireland (CCPR/C/IRL/CO/3), para. 13; Madagascar (CCPR/C/MDG/CO/3), para. 14; Mali (CCPR/CO/77/MLI), para. 14; Peru (CCPR/CO/70/PER), para. 20; Poland (CCPR/C/79/Add.110), para. 11; Zambia (CCPR/C/ZMB/CO/3), para. 18; CEDAW concluding observations: Belize (A/54/38), para. 56; Colombia (A/54/38), para. 393; Dominican Republic (A/53/38), para. 337; Myanmar, (A/55/38), para. 129; Committee against Torture (CAT) concluding observations: Chile (CAT/CR/32/5), para. 4(h); Nicaragua (CAT/C/NIC/CO/1), para. 16. See also: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), art. 14, para. 2(c), adopted at the 2nd Ordinary Session of the Assembly of the Union, 2003.

⁵⁶ CESCR, general comment No. 14, paras. 8 and 12.

25. Specifically, the right to health requires that particular measures be taken in relation to pregnancy and childbirth, including the provision of reproductive and maternal health care. ICECSR states that “special protection should be accorded to mothers during a reasonable period before and after childbirth” (art. 10, para. 2), and the Convention on the Elimination of All Forms of Discrimination against Women establishes that “States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation” (art. 12, para. 2).⁵⁷ ICECSR also requires the provision of reproductive and maternal (pre- as well as post-natal) health care.⁵⁸ Numerous other international and regional human rights instruments and bodies have elaborated on States’ obligations with respect to access to family planning, pre- and post-natal care, skilled delivery, emergency obstetric care and access to safe abortion and post-abortion care.⁵⁹

26. Evidence shows that access to voluntary family planning can reduce maternal deaths by between 25 and 40 per cent.⁶⁰ For example, contraception contributes to lowering teenage pregnancy rates.⁶¹ CEDAW has urged Governments to take measures to provide access to contraception and family planning services.⁶²

27. Unsafe abortion is one of the five major direct causes of maternal deaths and can result in permanent injuries and death due to complications.⁶³ Unsafe abortion accounts for 13 per cent of maternal deaths, and 20 per cent of the total mortality and disability burden due to pregnancy and

⁵⁷ See also the Programme of Action of the International Conference on Population and Development (ICPD), (A/CON.17/13), para. 7.3.

⁵⁸ CESCR, general comment No. 14, para. 44(a).

⁵⁹ CESCR, general comment No. 14, para. 14; CEDAW, general recommendation No. 24, para. 27; Maputo Protocol (art. 14, para. 2). See also for example: CEDAW concluding observations: Cape Verde (CEDAW/C/CPV/CO/6), para. 30; Indonesia (CEDAW/C/IDN/CO/5), para. 37; Togo (CEDAW/C/TOG/CO/5), para. 29; CESCR concluding observations: Kenya (E/C.12/KEN/CO/1), para. 33; Nepal (E/C.12/NPL/CO/2), para. 46; CRC concluding observations: Cambodia (CRC/C/15/Add.128), para. 52; Kazakhstan (CRC/C/KAZ/CO/3), para. 52(b); Maldives (CRC/C/15/Add.91), para. 19.

⁶⁰ World Bank, “World’s progress on maternal health and family planning is insufficient”, July 2009, available from <http://go.worldbank.org/70P0CCPUF0>. See also UNFPA at www.unfpa.org/public/mothers/pid/4382.

⁶¹ See for example the response of New Zealand to the note verbale, citing UNFPA Pacific Sub-Regional Office Technical Services, *Paper No. 001/2008*, which reported that teenage pregnancy rates in Kiribati, Marshall Islands, Nauru, Papua New Guinea, Solomon Islands, and Vanuatu are amongst the highest in the world.

⁶² CEDAW, general recommendation No. 24, paras. 2, 17, 23, 28 and 31(c); CEDAW concluding observations: Belize (A/54/38), paras. 56-57; Philippines (CEDAW/C/PHI/CO/6), para. 27.

⁶³ See paragraph 6 of the present study.

childbirth.⁶⁴ Every year, there are 65,000 to 70,000 deaths and close to five million women with temporary or permanent disability due to unsafe abortion.⁶⁵ According to WHO, the degree of legal access to abortion co-determines the frequency and related mortality of unsafe abortion. Evidence also shows that women who seek abortion will do so regardless of legal restrictions. Where there are few restrictions on the availability of safe abortion, deaths and illnesses are significantly reduced.⁶⁶ Treaty bodies have expressed concern over the impact of unsafe abortion-related deaths and disabilities not only on women's right to life but also their right to health.⁶⁷

28. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive health care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality.⁶⁸ Other key criteria include acceptability and accessibility of information.⁶⁹ Ensuring availability entails increasing care and improving human resources strategies, including increasing the number and quality of health professionals. Physical access to and the cost of health services often influence whether women are able to seek care. Ensuring women's access to maternal health and other sexual and reproductive health services may require addressing discriminatory laws, policies, practices and gender inequalities in health care and in society. Laws or policies that restrict women's access to information on sexual and reproductive health have a direct impact on maternal mortality. Preventing maternal mortality includes scaling up technical interventions and making them affordable, but also ensuring that services are sensitive to the rights, cultures and needs of pregnant women, including those from indigenous peoples and other minority groups. Maternal health care services must be medically appropriate, as

⁶⁴ WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, 5th ed. (Geneva, 2007), p. 5.

⁶⁵ *Ibid.*

⁶⁶ WHO, *Women and Health*, pp. 42-43.

⁶⁷ See for example: CEDAW concluding observations: Cameroon (CEDAW/C/CMR/CO/3), para. 40; CESCR concluding observations: Kenya (E/C.12/KEN/CO/1), para. 33; Trinidad and Tobago (E/C.12/1/Add.80), 2002, para. 23; CRC concluding observations: Democratic People's Republic of Korea (CRC/C/15/Add.239), para. 50; Ukraine (CRC/C/15/Add.151), para. 57.

⁶⁸ A/61/338, para. 17.

⁶⁹ P. Hunt and J. Bueno de Mesquita, *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health* (University of Essex, n.d.), p. 6.

quality of care often influences the outcome of interventions and a woman's decision to seek care.

29. However, the right to health goes beyond access to health care, and maternal mortality and morbidity are affected by a number of underlying social, economic, cultural and political determinants of health and structural barriers.⁷⁰ These determinants include nutrition, water and sanitation, information on sexual and reproductive health, economic exclusion and discrimination, non-discrimination and gender equality.

3. Rights to education and information

30. The realization of the right to education is essential to women's ability to enjoy the full range of human rights. Moreover, a comprehensive understanding of sexual and reproductive health is imperative to ensuring individuals' ability to protect their health and make informed decisions about sexuality and reproduction. Women's low rates of literacy and education worldwide correlate strongly to high rates of maternal mortality and adversely to other indices of maternal health, including fertility rate, utilization of prenatal care, met need for contraception and higher age at first birth. Lack of education affects women's health by limiting their knowledge of nutrition, birth spacing and contraception. Additionally, in some countries, education can be a key determinant of quality of care, with less-educated women facing greater discrimination within health-care facilities.

31. The rights to information and the benefits of scientific progress are firmly rooted in the most fundamental human rights, including the rights to life, health, education and non-discrimination. Access to information is a necessary part of women's ability to make informed choices with respect to their sexual and reproductive lives and to access health services needed to ensure healthy pregnancy and delivery. In article 16, paragraph 1(e), of the Convention on the Elimination of All Forms of Discrimination against Women, it is established that States must provide "access to the information, education, and means" to enable women to decide freely and responsibly on the number and spacing of their children. The Committee on the Rights of the Child has emphasized that States "should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early

⁷⁰ A/61/338, para. 18.

pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases".⁷¹ The right to the benefits of scientific progress, as explicitly recognized in ICESCR (art. 15, para. 1), is particularly salient in the maternal mortality and morbidity context, as numerous low-cost health interventions, to which women are entitled access, could substantially reduce maternal death and disability.⁷²

C. Human rights-based approach to maternal mortality and morbidity

32. The practical implications of the human rights values of dignity and non-discrimination result in a set of working principles that form the basis of a human rights approach. The treaty bodies and United Nations experts have clarified the importance of seven such principles: accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination.⁷³ These principles have particular application when examining a human rights-based approach to addressing maternal mortality and morbidity as discussed in this section.

1. Accountability

33. Accountability is at the core of the enjoyment of all human rights and has two main components: addressing past grievances and correcting systemic failure to prevent future harm. Accountability is sometimes narrowly understood to mean blame and punishment, whereas it is more accurately regarded as a process to determine what is working (so it can be repeated) and what is not (so it can be adjusted).⁷⁴

34. The Human Rights Committee has articulated State obligations regarding accountability in the context of the right to life, in the form of a State obligation to prevent, investigate or redress harm caused by acts of private persons or entities.⁷⁵ In this connection, the Committee

⁷¹ CRC, general comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child (2003), para. 28.

⁷² Furthermore, in its resolution 11/8, the Human Rights Council has recognized that preventable maternal mortality requires effective promotion and protection of the rights of women and girls to enjoy the benefits of scientific progress, among other rights.

⁷³ Non-discrimination is dealt with in section A of the present chapter; we will therefore lay out only the other six principles.

⁷⁴ Report of the Special Rapporteur on the right to health (A/HRC/4/28), para. 46.

⁷⁵ Human Rights Committee, general comment No. 31, para 8.

emphasized the need for administrative mechanisms to give effect to the obligation to investigate allegations of violations promptly, thoroughly, effectively and impartially.⁷⁶

35. CESCR has clarified that States must establish mechanisms and institutions that can that effectively address both the individual and the structural nature of harm caused by discrimination in the enjoyment of rights.⁷⁷ It has also specified that strengthening independent human rights structures and the participation of human rights advocates is an important element in ensuring relevant to human rights can function properly.⁷⁸ The Special Rapporteur on the right to health has defined accountability as “ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized, for all, including disadvantaged individuals, communities, and population”.⁷⁹

36. Regular monitoring of the health system and the underlying physical and socio-economic determinants of health that affect women’s health and ability to exercise their rights is a critical component of accountability. Without monitoring, systemic failures in reducing maternal mortality and morbidity cannot be corrected. When States adopt and implement a national public health strategy and plan of action,⁸⁰ they should also develop “appropriate indicators to monitor progress made, and to highlight where policy adjustments may be needed”.⁸¹ Monitoring helps States parties develop a better understanding of the “problems and shortcomings encountered” in realizing rights, providing them with the “framework within which more appropriate policies can be devised”.⁸² Data based on appropriate indicators should be disaggregated on the basis of the prohibited grounds of discrimination to monitor the elimination of discrimination⁸³ as well as to ensure that vulnerable communities are benefiting from health-care schemes.

37. As an accountability measure designed to reduce maternal mortality, the Special Rapporteur on the right to health has strongly recommended that all States introduce, as a matter of urgency, a comprehensive, effective registration system, as well as a system of maternal death

⁷⁶ Ibid., para. 15.

⁷⁷ CESCR, general comment No. 20, para. 40.

⁷⁸ CESCR, general comment No. 14, paras. 59-62.

⁷⁹ Report of the Special Rapporteur on the right to health (A/63/263), para. 12.

⁸⁰ CESCR, general comment No. 14, para. 43(f).

⁸¹ A/61/338, para. 28(e).

⁸² CESCR, general comment No. 1: Reporting by States Parties (1989), para. 8.

⁸³ CESCR, general comment No. 20, para. 41.

audits, in order to find out why the deaths occurred. Such maternal death audits, the Special Rapporteur notes, should be a non-judicial review that goes beyond medical reasons to identify the social, economic and cultural reasons that led or contributed to the death.⁸⁴

38. The principle of accountability is closely linked to the right of victims to remedy including reparation.⁸⁵ Effective access to remedies and reparation contributes to a constructive accountability framework by focusing on system failures and encouraging repair. The components of remedies and reparation were articulated through the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law approved by the General Assembly in 2005.⁸⁶

2. Participation

39. Participation is an operational principle of a rights-based approach that has come to be recognized as a right in itself. At the International Conference on Primary Health Care in Almaty in 1978, 134 Governments and 67 international organizations agreed that “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care”.⁸⁷ Participation in the context of maternal mortality and morbidity means granting women access to relevant information and including them in the decision-making processes which affect their pregnancy and childbirth. The Special Rapporteur on the right to health has noted, in the context of reducing maternal mortality and morbidity, that the “right to health includes an entitlement to participate in health policymaking ... [because this] will help develop more effective and sustainable programmes, reduce exclusion and enhance accountability”.⁸⁸

3. Transparency

40. Without transparency, there cannot be meaningful accountability or participation. The State is obligated to provide transparent accountability processes to enable citizens to participate

⁸⁴ Report of the Special Rapporteur on the right to health (A/HRC/7/11/Add.4), para. 16.

⁸⁵ CESCR, general comment No. 14, para. 59.

⁸⁶ General Assembly resolution 60/147, annex.

⁸⁷ Declaration of Alma-Ata, para. IV.

⁸⁸ A/61/338, para. 28(c).

fully in the review and refocusing of public policies.⁸⁹ CESCR has pointed out that health strategies and plans of action need to be devised and reviewed “on the basis of a participatory and transparent process”.⁹⁰ The Special Rapporteur on the right to health emphasizes that although States have some discretion in choosing appropriate monitoring and accountability mechanisms, “all mechanisms must be effective, accessible and transparent”.⁹¹

4. Empowerment

41. As mentioned in the section on equality and non-discrimination above, preventable mortality and morbidity is closely linked to inequitable access to health resources, information and other human rights. Conversely, gender equality and empowerment play a key role in preventing maternal mortality because they lead to greater demand by women for family planning services, antenatal care and safe delivery.⁹² In addition, the effectiveness of accountability mechanisms, which in turn render health policies more effective, depends on the use made of these mechanisms. Therefore, CESCR has called for the provision, where possible, of legal aid to victims of potential human rights violations in order for accountability mechanisms to be effective.⁹³ In the context of maternal mortality and morbidity, access to information, and the education to take advantage of this information, is crucial to women and girls being able to take advantage of existing mortality reduction schemes. Empowerment therefore becomes the precursor for effective policies.

5. Sustainability

42. Reducing preventable maternal mortality and morbidity requires a long-term investment in health policies and programmes to further the empowerment of those women who are particularly at risk. Such sustainability has been highlighted as key to successful initiatives to

⁸⁹ See for example CESCR, general comment No. 20, para. 40.

⁹⁰ CESCR, general comment No. 14, para. 43(f).

⁹¹ A/61/338, para. 65.

⁹² Hunt and Bueno de Mesquita, *Reducing Maternal Mortality*, p. 7.

⁹³ See for example CESCR, general comment No. 7: The right to adequate housing (art. 11.1): forced evictions (1997), para. 15.

guarantee both the underlying physical determinants of health, such as water, and health care access itself.⁹⁴

6. International assistance

43. While the prevention of maternal mortality and morbidity in some cases depends on the provision of relatively economical and simple interventions, deaths cannot be fully prevented without an overall functioning health system and a stable infrastructure for transportation of implements and patients, as well as a system for education, the provision of information, and accountability.⁹⁵ The strengthening of these systems is beneficial to all citizens, not just women. It is, however, also costly, and illustrates clearly the interlinkages among development, human rights and public health.

44. In this connection, the Special Rapporteur on the right to health has emphasized that: “The right to health gives rise to a responsibility of international assistance and cooperation on developed States to assist developing States to realize the right to health. Developed States should support developing States’ efforts to reduce maternal mortality. This responsibility is reflected in Millennium Development Goal 8, which is a commitment to develop a global partnership for development.”⁹⁶ Thus, donor countries have a responsibility to provide international cooperation and assistance.

IV. OVERVIEW OF INITIATIVES AND ACTIVITIES WITHIN THE UNITED NATIONS SYSTEM AND BEYOND TO ADDRESS ALL CAUSES OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY

45. An exhaustive overview of all major existing global initiatives and activities to address preventable maternal and mortality would be overwhelming in length. A preliminary analysis of the types of activities, roughly categorized under normative and policy development, service provision, and accountability, confirms the significant number of existing initiatives but also highlights the need for coherence and enhanced action in specific areas.

A. Normative and policy development

⁹⁴ A/61/338, in particular paras. 28(c), 84 and 95. See also CESCR, general comment No. 15: The right to water (arts. 11 and 12) (2002), para. 11.

⁹⁵ A/61/338, para. 19.

⁹⁶ *Ibid.*, para. 20.

46. The elaboration on human rights law by human rights mechanisms referred to extensively in the present report has not been done in isolation, but alongside commitments made by States in international conferences and global initiatives. In 1994 the Cairo International Conference on Population and Development adopted a Programme of Action, identifying as objectives, among others, the promotion of women's health and safe motherhood, the achievement of a rapid and substantial reduction in maternal morbidity and mortality, and the reduction in the differences observed between and within developed and developing countries. Recognizing the impact of unsafe abortion as "a major public health concern", the Programme of Action urges Governments to spare no effort in preventing high-risk pregnancies and births, particularly those of adolescents, as well as unwanted pregnancies and "to reduce the recourse to abortion through expanded and improved family planning services".⁹⁷ The Programme of Action further states in paragraph 8.25 that: "in circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion." At the United Nations five-year review of the Programme of Action, it was agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible".⁹⁸

47. In the Beijing Declaration and Platform for Action (1995), States resolved to strengthen and reorient health services in order to ensure universal access to quality health services for women and girls, reduce ill health and maternal morbidity and achieve worldwide the agreed upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015. Commitments were made to ensure that the necessary services are available at each level of the health system, and to make reproductive health care accessible, through the primary health-care system, to all individuals of appropriate ages (para. 107(i)). The Beijing Declaration and Platform of Action further recognized the health impact of unsafe abortion as a major public health concern (para. 107(j)), confirming the position taken in the International Conference on Population and Development, and Governments agreed

⁹⁷ Programme of Action of the International Conference on Population and Development (ICPD), para. 8.25.

⁹⁸ Report of the Ad Hoc Committee of the Whole, "Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development" (A/S-21/5/Add.1), para. 63(iii).

to consider reviewing laws containing punitive measures against women who have undergone illegal abortion (para. 107(k)).

48. At the Millennium Summit in 2000, States resolved to reduce maternal mortality by three quarters by the year 2015. This commitment is encapsulated in the Millennium Development Goals, which derive from the Millennium Summit commitments, and which have come to play a defining role in international development efforts. Specifically Goal 5 concerns improving maternal health and ensuring universal access to reproductive health care.

49. The World Health Assembly has confirmed a global consensus around cornerstone interventions: family planning, skilled birth attendance, emergency obstetric and newborn care.⁹⁹ WHO is currently revising its publication *Safe Abortion: Technical and Policy Guidance for Health Systems* and producing new clinical practice guidelines for health providers in order to further assist countries in providing safe abortion care.

B. Services

50. UNICEF, UNFPA, the World Bank and WHO have recently joined efforts to accelerate progress in reducing maternal mortality and morbidity, with the right to health as a central principle, and through a human rights approach to United Nations country programming. The joint initiative is collectively known as the “Health 4” or “H4”. During the coming year, the four agencies will enhance their support to the countries with the highest maternal mortality, starting with 6, scaling up to 25, with an expansion to 60 countries.¹⁰⁰ Through the “H4”, in partnership with other stakeholders, the organizations are, inter alia: costing national plans and rapidly mobilizing required resources; scaling up quality health services to ensure universal access to reproductive health, especially with respect to family planning, skilled attendance at delivery and emergency obstetric and newborn care; ensuring linkages with HIV prevention and treatment; and addressing the urgent need for skilled health workers, particularly midwives.

51. Other joint initiatives include: the International Planned Parenthood Federation (East and South-East Asia and Oceania Region) initiative entitled “SPRINT” aimed at increasing access to

⁹⁹ UNFPA, UNICEF and WHO joint response to the note verbale.

¹⁰⁰ UNFPA response to the note verbale, p. 12.

sexual and reproductive health information and services for populations surviving crisis and living in post-crisis situations;¹⁰¹ and the joint International Confederation of Midwives/UNFPA Global Programme on Midwifery promoting the professionalization of the midwifery practice in 12 African countries, supporting national efforts to improve national midwifery standards and helping countries to scale up community-based midwifery practice.¹⁰²

52. United Nations programmes and agencies also continue to assist countries in this area. UNFPA, UNICEF and WHO support nationally owned initiatives on maternal health in more than 90 countries. At the request of the Governments, UNFPA, UNICEF and WHO support these countries in taking the lead to strengthen their health care systems and scale up efforts to deliver better health outcomes, particularly for persons living in poverty or in situations of vulnerability. UNFPA and WHO work with countries to ensure that sexual and reproductive health is fully integrated and prioritized into national frameworks and plans, and that corresponding resources are made available. UNFPA and WHO include maternal health as part of a package of interventions in the area of sexual and reproductive health, along with family planning. In 2008, UNFPA established the Maternal Health Thematic Fund aimed at increasing available funding to support the capacities of health systems to provide a broad range of quality maternal health services, reduce health inequities and empower women to exercise their right to maternal health. Assistance under this initiative has included technical and financial support to high maternal mortality countries to accelerate progress towards Millennium Development Goal 5.

53. Other service-related initiatives directly target risk factors, such as early marriages, female genital mutilation/cutting or HIV. The Berhane Hewan programme in Ethiopia's Amhara region, where rates of child marriage and maternal mortality rates are among the highest in the world, follows a conditional cash transfer model by encouraging families to allow their girls to participate in the programme rather than to marry them off. Both married and unmarried girls in the programme develop functional literacy, life skills, livelihood skills and reproductive health education. Upon successful completion, the girls and families receive modest rewards. In Guatemala, the UNFPA-sponsored *Abriendo Oportunidades* programme also works with marginalized girls at risk of child marriage. Through the programme, the girls gain leadership,

¹⁰¹ The Sprint initiative is carried out in partnership with the Government of Australia, UNFPA, the Australian Reproductive Health Alliance and the University of New South Wales.

¹⁰² UNFPA response to the note verbale, p. 13.

entrepreneurial and life skills, as well as information about gender equality and reproductive health.

54. In the context of its programme on Child and Adolescent Health and Development, WHO is working to strengthen the response of reproductive health programmes to adolescents in order to put in place a complementary set of actions aimed at preventing too early and often unwanted pregnancy, unsafe abortion and mortality resulting from it, and mortality during childbirth and the post-natal period. To this end, the organization is generating evidence, developing methods and tools, building capacity and consensus and strengthening collaboration.

55. In 2007, UNICEF and UNFPA launched a joint programme entitled “Female Genital Mutilation/Cutting: Accelerating Change” with the objective of contributing to a 40 per cent reduction of the practice among girls aged 0-15 years, with at least one country declared free of female genital mutilation/cutting by 2012. The two agencies are also working with WHO, especially on stemming the trend of the medicalization of this harmful practice.¹⁰³ Through a culturally sensitive approach, the joint programme fosters partnerships with government authorities both at decentralized and national levels, religious authorities and local religious leaders, the media, civil society organizations and the education and reproductive health sectors.

56. UNAIDS, UNFPA, WHO and other entities provide technical support to scale up comprehensive prevention of perinatal transmission of HIV, which includes (a) integration of HIV counselling and testing and other services such as safe delivery and infant feeding in maternal health care settings, (b) advocacy to meet the sexual and reproductive health and reproductive rights of women living with HIV (including information on their right to determine the number and spacing of their children) and (c) access to family planning and other sexual and reproductive health services.¹⁰⁴

C. Accountability

¹⁰³ The joint programme is currently supporting action in 12 countries in Africa: Burkina Faso, Djibouti, Egypt, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Kenya, Senegal, Somalia, Sudan and Uganda. See the UNFPA response to the note verbale, p. 13.

¹⁰⁴ UNFPA response to the note verbale, p. 11.

57. The human rights mechanisms represent a developed framework to ensure accountability at the international level, including through complaints mechanisms established through optional protocols to the Convention on the Elimination of All Forms of Discrimination against Women and ICESCR. In the context of measuring State compliance with international, regional and national human rights standards, WHO and the Program on International Health and Human Rights, Harvard School of Public Health, have developed a tool that provides a method for countries to use a human rights framework to identify and address legal, policy and regulatory barriers to peoples' access to, and use of, maternal health services, and to the provision of quality services. The tool has been field tested and used in more than 10 countries.¹⁰⁵

V. CONCLUSIONS AND RECOMMENDATIONS

58. In its resolution 11/8, the Human Rights Council specifically calls for recommendations on how the Council can add value to existing initiatives through a human rights analysis, including efforts to achieve Millennium Development Goal 5 on improving maternal health, and options for better addressing the human rights dimensions of preventable maternal mortality and morbidity throughout the United Nations system. With the adoption of the resolution, the Human Rights Council has explicitly requested States to “redouble their efforts to ensure the full and effective implementation of their human rights obligations” (para. 3) in the context of eliminating preventable maternal mortality and morbidity. While the work of the United Nations human rights mechanisms, international and regional actors has progressively elaborated on the human rights dimensions of maternal mortality, as well as on the human rights violations that need to be addressed, prevented or remedied in this area, the value of a collective commitment to a human rights approach cannot be overestimated. In particular, the existence of maternal mortality and morbidity is fundamentally linked to violations of the human 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

¹⁰⁵ Hunt and Bueno de Mesquita, *Reducing Maternal Mortality*, p. 10.

reproductive health”¹⁰⁶ and “requires the effective promotion and protection of the human rights of women and girls”¹⁰⁷ as detailed by the treaty bodies and summarized in this study.

59. It is clear that human rights have an important role to play in developing effective approaches to addressing this global problem through public health schemes. A number of steps that are essential to effectively address maternal mortality and morbidity have been identified as part of human rights standards, including the establishment of accessible, transparent and effective mechanisms of monitoring and accountability and of ensuring women’s rights to participate in decision-making processes that affect their pregnancy and childbirth. Related State obligations, which also include procedural obligations, are underpinned by several specific human rights principles: accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination. Giving effect to these principles is the core of a human rights-based approach to the eradication of preventable maternal mortality and morbidity. While maternal mortality and morbidity is global in nature, States and other actors giving international assistance and technical cooperation need also to approach their work to address maternal mortality and morbidity from a human rights-based perspective.

60. The Council has called for the integration of consideration of the human rights dimensions of preventable maternal mortality and morbidity into its mechanisms, particularly the universal periodic review and special procedures, by encouraging States and other actors to give increased attention to this issue in their engagement with the United Nations human rights system.¹⁰⁸ In answering this call of the Council, Member and Observer States could give additional attention to systematically addressing the human rights dimensions of maternal mortality and morbidity in their reporting under the universal periodic review processes as well as to considering this issue when reviewing other States. The Council could also consider requesting States to report on certain human rights aspects of addressing preventable maternal mortality and morbidity during the universal periodic review. Another important part of this would be for the Council to invite United Nations agencies, funds and programmes that are undertaking initiatives and

¹⁰⁶ Human Rights Council resolution 11/8, para. 2.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid., para. 5.

activities in relation to maternal mortality and morbidity to systematically contribute information for consideration in the universal periodic review. As the above discussion shows, the issue of maternal mortality and morbidity is not simply a matter of the right to health but cuts across a number of rights and thematic human rights issues. Thus, special procedures could also be encouraged by the Council to integrate consideration of the human rights dimensions of preventable maternal mortality and morbidity within the scope of their respective mandates.

61. How the substantive human rights framework applies to the context of preventable maternal mortality and morbidity has been laid out thoroughly within the work of treaty bodies as well as that of other international experts and regional bodies. However, what is missing is the operationalization of a human rights-based approach to maternal mortality and morbidity. That is, many questions remain unanswered, such as: What are specific steps that can be taken to implement/adopt a human rights-based approach to eliminating preventable maternal mortality and morbidity? How can States ensure that constructive accountability mechanisms developed are consistent with human rights principles? What is the range of constructive accountability mechanisms that can be used to ensure effective reduction of maternal mortality and morbidity? What is needed to ensure that a constructive accountability mechanism is participatory, effective, and transparent?

62. This operationalization is inherently a large process requiring systematization and is currently without a clear lead within the United Nations system. Without doubt, there is much good practice that States and other actors can helpfully share, ensuring that such good practice relates specifically to the implementation of a human rights-based approach to maternal mortality and morbidity. While the universal periodic review is one forum for such sharing, there is much scope at this time for good practice to be collected in a systematic and thorough fashion. Implementation and monitoring of such an operational framework are also necessary; however, they have not been a priority at the international level. The Council could spearhead efforts to move forward on such implementation and monitoring activities.

63. As discussed earlier, of all the Millennium Development Goals, Goal 5 is the furthest from being realized. Despite efforts to reduce maternal mortality globally, very little

progress has actually been made in the last 20 years. Given this, there is clearly much scope for the Council to make constructive and effective contributions to the global effort to eliminate maternal mortality and morbidity through its mandate to promote and protect human rights. There are a number of recommended options for the Council's consideration relating to promoting a human rights-based approach to addressing preventable maternal mortality and morbidity. The options presented below are not mutually exclusive, but rather reinforce one another. In the short term, such steps could include making a contribution in relation to the human rights dimensions of maternal mortality and morbidity to the High-level Plenary Meeting of the General Assembly in September 2010 reviewing the progress made towards achieving the Millennium Development Goals and forwarding the present study for the attention of the Sixty-fourth World Health Assembly. Such steps would be consistent with the Council's mandate of mainstreaming human rights within the United Nations system.

64. Additional steps the Council could take would be to further the operationalization of a human rights-based approach to maternal mortality and morbidity. This could involve, as an initial step, the collection of good practices from States and other actors as to addressing maternal mortality and morbidity from a human rights perspective. Such a compilation of good or effective practice would be an important and necessary contribution or foundation for an expert consultation co-hosted by relevant United Nations agencies that would look at the operational aspects of a rights-based approach to maternal mortality and morbidity in greater detail. The outputs of such a large-scale consultation could be presented to the Council for its consideration.

65. As a final step, while there is already much ongoing inter-agency dialogue and collaboration within the United Nations (and Bretton Woods) systems on the issue of maternal mortality and morbidity, there is further scope for work on the human rights dimensions of this topic to be strengthened through Office of the High Commissioner for Human Rights (OHCHR) participation in this dialogue and collaboration, particularly with UNFPA, UNICEF, WHO and the World Bank. Such participation would allow OHCHR to assist this collaboration by offering human rights expertise and at the same time would also allow for the building of OHCHR capacity in this area through the

interaction with agencies having a range of specialized technical expertise in maternal mortality and morbidity.
