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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

Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights

Report of the Office of the United Nations High Commissioner for Human Rights

Summary

The present study, submitted pursuant to Human Rights Council resolution 15/17, contains an analytical compilation of good and effective practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity. It identifies the common features of such practices, analyses how they embody a human rights-based approach, and showcases some good practices that have been effective in reducing maternal mortality and morbidity.

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I. Introduction

1. In its resolution 15/17, the Human Rights Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to prepare an analytical compilation of good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity, that included (a) an identification of how such initiatives embodied a human rights-based approach; (b) the elements of these initiatives that succeeded in achieving a reduction in maternal mortality and morbidity through a human rights-based approach; and (c) ways in which similar initiatives could give effect more fully to a human rights-based approach. For the purpose of the present report, a note verbale was addressed in January 2011 to States, United Nations agencies and the World Bank, national human rights institutions, all United Nations special procedures, the Committee on the Elimination of All Forms of Discrimination against Women and civil society organizations. Written contributions[1] were received from 54 States,[2] three United Nations agencies (the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO)), five national human rights institutions,[3] the Special Rapporteur on violence against women, its causes and consequences, and 14 civil society organizations.[4]

II. A human rights-based approach to maternal mortality and morbidity

2. In its resolution 11/8, the Human Rights Council called on States to integrate a human rights perspective into their initiatives to reduce maternal mortality and morbidity. Other instruments requesting such an approach to address maternal mortality and morbidity over the past year include resolution 24/5 of the Commission on the Status of Women on eliminating preventable maternal mortality and morbidity and the empowerment of women; the report of the Secretary-General entitled "Keeping the promise: a forward-looking review to promote an agreed action agenda to achieve the Millennium Development Goals by 2015" (A/64/665) and the Global Strategy for Women and Children's Health.

3. The substantive human rights framework applicable to preventable maternal mortality and morbidity was laid out thoroughly by the treaty bodies, other international

[1] All submissions are available on the OHCHR website at http://www2.ohchr.org/english/issues/women/.

[2] Algeria, Australia, Argentina, Bahrain, Belarus, Belgium, Brazil, Bulgaria, Burkina Faso, Canada, Chile, Colombia, Costa Rica, Cuba, Cyprus, the Dominican Republic, Egypt, El Salvador, Estonia, Ethiopia, Finland, Germany, Guatemala, Hungary, Indonesia, Iran (Islamic Republic of), Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Madagascar, Mexico, Myanmar, New Zealand, Nicaragua, Norway, Oman, Pakistan, Peru, the Philippines, Portugal, Qatar, the Russian Federation, Saudi Arabia, Senegal, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, the Syrian Arab Republic, Timor-Leste, Togo and Ukraine.

[3] The Ombudsman of Azerbaijan, the National Human Rights Commission of Nicaragua, the National Human Rights Commission of Nigeria, the Human Rights Commission of New Zealand and the South African Human Rights Commission.

[4] Action Aid Sierra Leone and Marie Stopes Sierra Leone, BRAC Bangladesh, the Center for Economic and Social Rights, the Center for Reproductive Rights, Enfants du Monde, the Family Planning Association for Bangladesh, the International Alliance of Women, the International Planned Parenthood Federation, IPAS Brazil, IPAS USA, the Medical Collaboration Committee, the National Association for Women Organizations in Uganda and Pathfinder International.

experts and regional bodies, and summarized in the OHCHR report on preventable maternal mortality and morbidity and human rights (A/HRC/14/39). State obligations are underpinned by seven specific human rights principles: equality and non-discrimination, participation, empowerment, transparency, sustainability, international cooperation and accountability. Giving effect to these principles is at the core of a human rights-based approach to the elimination of maternal mortality and morbidity and to achieve Millennium Development Goal 5 on maternal health.

4. International human rights treaties and their interpretation by human rights bodies have made clear that many of the obligations that States must undertake to prevent maternal mortality and morbidity are not subject to progressive realization but are of immediate effect.[5] The International Covenant on Economic, Social and Cultural Rights recognizes that the Covenant also imposes certain core obligations; the Committee on Economic, Social and Cultural Rights, in its general comment no. 14, emphasized that a State party could not, under any circumstances whatsoever, justify its non-compliance with the core obligations, which are non-derogable. In the same comment, the Committee stated that the provision of maternal health services is a core obligation: 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. In its general recommendation, the Committee on the Elimination of Discrimination against Women emphasized that States are required to ensure services for maternal health and equality in access to health services: denying services that only women need is a form of discrimination. Moreover, the right to life and other civil and political rights, and the right to non-discrimination, are not subject to progressive realization.[6]

III. Common features of good and effective practices to reduce maternal mortality and morbidity using a human rights-based approach

5. The current rate of global decline is insufficient to achieve the Millennium Development Goal target of reducing maternal mortality ratios by three quarters between 1990 and 2015.[7] Good and effective practices to eliminate mortality and morbidity using a human rights-based approach may be complex and specific to the local situation, but, an analysis of all responses to the note verbale sent by OHCHR reveal that they share five features:

(a) Broad social and legal changes to enhance women's status by promoting gender equality and eliminating harmful practices;

(b) Increasing access to contraception and family planning to enable women and adolescent girls to make decisions regarding their sexuality and fertility, including delaying and limiting childbearing and preventing sexually-transmitted infections, including HIV/AIDS, supported by access to education on sexuality and sexual and reproductive health;

[5] Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (art. 12), para. 11.

[6] See Human Rights Committee, general comment No. 6 (art. 6) on the right to life, para. 5; and Committee on Economic, Social and Cultural Rights, general comment No. 20 (art. 2, para. 2), para. 7.

[7] A/64/665, para. 30.

(c) Strengthening health systems and primary health care to improve access to, and use of, skilled birth attendants and emergency obstetric care for complications;

(d) Addressing unsafe abortion for women;

(e) Improving monitoring and evaluation of State obligations to ensure the accountability of all actors and to implement policies.

A. Enhancing the status of women by removing barriers to an effective human rights-based approach to eliminate maternal mortality and morbidity

6. Maternal mortality and morbidity is a consequence of gender inequality, discrimination, health inequity and a failure to guarantee women's human rights. The slow progress with regard to Millennium Development Goal 5 is testimony to the low value placed on women's and girls' lives and to their limited voice in setting public priorities. The inequality and discrimination suffered by women throughout their lifetimes is perpetuated by formal laws, policies and harmful social norms and practices. Women, especially young women, those living in poverty, and/or socially marginalized women, are often unable to have access to care because of harmful, stigmatizing or discriminatory laws and practices. Consequently, many women and adolescent girls cannot obtain the full range of sexual and reproductive health services and information to which they are entitled.[8]

7. Poor and less educated women and girls and those living in rural areas are far less likely to have access to health services or to give birth in the presence of a skilled health worker owing to physical inaccessibility and the prohibitive costs of a birthing facility, restrictive abortion services, patriarchal household decision-making processes and poor quality and/or disrespectful care, including poor health-care provider attitudes towards pregnant women living with HIV.

8. The risk increases further for women facing intersecting discrimination, for example, on the basis of age, marital status, disability, HIV/AIDS status, women of lower caste or socio-economic status, living in rural areas or slum dwellings, or indigenous, minority, migrant, displaced or refugee women. A human rights-based approach requires taking measures to identify and address reasons behind specific women's heightened inability to have access to adequate and timely health-care interventions and services.

9. A comprehensive human rights-based approach to maternal mortality and morbidity must ensure women's equality in decision-making through a series of interventions, including legislative, policy and operational measures. Political commitment, enabling policies and the promotion of cross-sectoral linkages are needed to reduce poverty, improve women's education and nutritional status, improve water and sanitation, infrastructure and transportation, empower women and address gender-based violence and harmful practices.

1. Early marriage

10. Early marriage exposes young girls to greater risk of maternal mortality and morbidity. According to WHO, although not all childbearing occurs within marriage, age at marriage is closely linked to first birth due to cultural norms and expectations, and due to

[8] UNICEF, UNFPA, WHO, *Addressing the human rights dimension of preventing maternal mortality and morbidity: a joint report to the Human Rights Council*, UNICEF submission, p. 1.

the fact that contraception is less commonly used to delay first births than it is to delay later births."[9]

11. Pregnancy-related complications are the main cause of death for young women, with girls being twice as likely to die from childbirth as women in their twenties.[10] The average age of obstetric fistula patients is below 25 years old, with many as young as 13 or 14 years.[11]

12. Marriage often entails an expectation to start a family. A woman's right to choose if, when and whom to marry is a fundamental human right, secured under a number of international human rights instruments. According to the Committee on the Elimination of Discrimination against Women, the minimum age of marriage should be 18 years, an idea supported by other treaty bodies.[12] While most countries claim that national laws comply, however, customs and tradition in reality do not, and laws on minimum age of marriage are not enforced.

13. Reflecting the correlation between early pregnancy and risk, a human rights-based approach involves promoting secondary school education, preventing early marriage by enforcing a set minimum legal age of marriage of at least 18 years, and delaying first births by postponing the onset of sexual activity and by using effective methods of contraception.

2. Inadequate nutrition

14. Inadequate nutrition can greatly increase the risks of preventable maternal mortality and morbidity.[13] In many countries, women and girls are greatly affected by lack of food, and family feeding patterns often leave women and girls last to be fed. Malnourishment hinders their pelvic growth, leading to obstructed labour, causing maternal mortality and obstetric fistula. A human rights-based approach requires States to address any traditional practice not allowing women to eat until men are fully fed,[14] and requires States to respect, protect and promote the right of women and girls to nutritional well-being.[15]

3. Violence against women

15. Violence against women and girls is a consistent barrier to good maternal health outcomes. Violence during pregnancy is associated with an increased risk of miscarriage, stillbirth, abortion and low birth weight.[16] A human rights-based approach requires States to eliminate such violence and to provide training to recognize its signs using appropriate approaches for treatment and counselling, and involving communities.

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[9] World Health Day, Safe Motherhood 1998. Delay childbearing, available from www.who.int/docstore/world-health-day/en/pages1998/whd98_04.html.

[10] World Bank, "Maternal mortality at a glance: why address maternal mortality?", May 2006. Available from http://siteresources.worldbank.org/INTPHAAG/Resources/AAGMatMort06.pdf.

[11] Medical Collaboration Committee submission.

[12] See Committee on the Elimination of Discrimination against Women, general recommendation No. 21, para. 36; Committee on Economic, Social and Cultural Rights, general comment No. 16; Human Rights Committee, general comment No. 28, para. 23; and Committee on the Rights of the Child, general comment No. 4, para. 9.

[13] A/HRC/14/39, para. 18.

[14] See Committee on Social, Economic and Cultural Rights, general comment No. 14, para. 28; and Human Rights Committee, general comment No. 6.

[15] Committee on the Elimination of Discrimination against Women, general recommendation No. 24, para. 7.

[16] World Health Organization (WHO), "Addressing violence against women and achieving the Millennium Development Goals"; see www.who.int/gender/documents/women_MDGs_report/en/index6.html.

4. Female genital mutilation

16. Female genital mutilation and cutting is a form of violence against women and a violation of women's and girls' rights. Girls and women who have undergone such mutilation experience a higher prevalence of infections, psychological and psychosexual trauma, infertility and obstetric complications,[17] which lead to an increased need for emergency obstetric care. A human rights-based approach advocates for the eradication of this harmful practice with strong support from international and regional human rights treaties and consensus documents.[18]

B. Sexual and reproductive health rights

17. The International Conference on Population and Development recognized reproductive rights as fundamental human rights and held contraceptive information and services to be essential for ensuring reproductive health and rights.[19] These rights are grounded in the right to life, the right to the highest attainable standard of health,[20] the right to decide the number and spacing of one's children,[21] the right to privacy,[22] the right to information[23] and the right to equality and non-discrimination.[24] Guaranteeing access to available, acceptable and good-quality contraceptive information and services free from coercion, discrimination and violence is critical for achieving gender equality and ensuring that women can participate as full members of society.

18. To achieve gender equality and non-discrimination, States are obligated to ensure that their laws, policies and practices meaningfully address the specific needs of women, including an obligation to ensure women's access to sexual and reproductive health information and services.[25]

19. Governments are obligated to take affirmative steps to ensure access to the full range of contraceptive methods by removing legal, financial, informational and other barriers.[26]

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[17] WHO, Estimating the obstetric cost of female genital mutilation in six African countries, WHO Bulletin 88: 281-288, cited in UNICEF submission, p. 1.

[18] WHO, "Eliminating female genital mutilation: an interagency statement", 2008, p. 8. Available from http://whqlibdoc.who.int/publications/2008/9789241596442_eng.pdf.

[19] A/CONF.171/13/Rev.1.

[20] Human Rights Committee, general comment No. 6, para. 5.

[21] See the Convention on the Elimination of All Forms of Discrimination against Women, art 16 (1)(e); the Convention on the Rights of Persons with Disabilities, art. 23(1)(b); and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), art. 14, para. 1.

[22] See Committee on the Elimination of Discrimination against Women, general recommendation No. 21, para. 22; Human Rights Committee, general comment No. 28, para. 20; and A/CONF.177/20, para. 96.

[23] Committee on the Rights of the Child, general comment No. 4, para. 28; A/65/162, paras. 19 and 24-37; Committee on Economic, Social and Cultural Rights, general comment No. 14, note 27.

[24] Committee on the Elimination of Discrimination against Women, general recommendation No. 24; Human Rights Committee, general comment No. 28; Committee on Economic, Social and Cultural Rights, general comment No. 16; *Official Records of the General Assembly, Fifty-third Session, Supplement No. 38* (A/53/38/Rev.1), paras. 228-29; ibid., *Fifty-second Session* (A/52/38/Rev. 1), para. 140.

[25] Committee on the Elimination of Discrimination against Women, general recommendation No. 24, para. 27; Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 14.

[26] See *Official Records of the General Assembly, Fifty-fourth Session, Supplement No. 38* (A/54/38/Rev.1), paras. 186 and 207; ibid., *Fifty-seventh Session* (A/57/38), para. 400; Committee on the Elimination of Discrimination against Women, general recommendation No. 24, para. 17; and Committee on Economic, Social and Cultural Rights, general recommendation No. 14, para. 27.

Restrictions on access to certain contraceptive methods and coercive family planning policies impair the ability of women to make informed, autonomous decisions and to determine the number, spacing and timing of their children.

20. Many barriers prevent young people, married and unmarried, from obtaining contraception and having access to services, including HIV prevention, denial that young people may be sexually active, requirements of parental or spousal consent, cost and location of services, and lack of privacy and confidentiality. The Committee on the Rights of the Child, in its general comment No. 4, found that the realization of the right to health of adolescents was dependent on the development of youth-sensitive health care that respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

C. Strengthening health systems to increase access to and use of skilled care

21. While many factors contribute to maternal deaths and disabilities, one of the most effective means of preventing them is to improve health systems and primary health care to ensure the availability of skilled attendance at all levels and access to 24-hour emergency obstetric care. Most maternal deaths and disabilities could have been prevented had the women been assisted by a health-care professional with the necessary skills, equipment and medicines to prevent and manage complications.

22. Interventions have traditionally been neglected in favour of increasing the supply of skilled birth attendants, whereas a human rights-based approach to reduce maternal mortality and morbidity recognizes that the availability of services alone is insufficient; they must also be accessible and affordable to all, of high quality, and should be provided in a way that is both culturally acceptable and responsive to women's needs. Overcoming such obstacles necessitates a human rights-based approach, as it requires creating an environment that is conducive the empowerment of women to demand these rights. Families and communities need to be able to recognize when complications arise and be able to take action.

23. A functioning health system requires adequate supplies, equipment and infrastructure, as well as an efficient and effective system of communication, referral and transport. The strengthening of these systems, however costly, is beneficial to all citizens, not just women, thereby illustrating the interlinkages among development, human rights and public health.

24. According to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 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,[27] and is further articulated in the Global Strategy for Women's and Children's Health. Accountability thus begins with State obligations, but the global community also has a responsibility to provide international cooperation and assistance to strengthen health systems.

[27] A/61/338, para. 19.

D. Addressing unsafe abortion

25. In his Global Strategy for Women's and Children's Health, the Secretary-General pointed out that unsafe abortion accounts for one out of every eight maternal deaths; in a statement made on 14 June 2010, the High Commissioner declared that States had obligations to address unsafe abortion. Unsafe abortion is one of the five major causes of maternal deaths.[28] Each year, there are around 47,000 deaths and between 5 and 8.5 million women with temporary or permanent disability or injury due to complications.[29]

26. On the basis of existing international law, several human rights bodies have called on Governments to review and amend restrictive abortion laws.[30] In its general recommendation 24 on women and health, the Committee on the Elimination of Discrimination against Women emphasized that the barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures, and recommended that legislation criminalizing abortion should be amended in order to withdraw punitive provisions imposed on women who undergo abortion. Similarly, other human rights treaty bodies have declared restrictive abortion laws and failure to ensure access to abortion when it is legal incompatible with international human rights law and amounting to violations of, inter alia, the rights to life and health and the principle of non-discrimination arising from the denial of access to safe and legal abortion and post-abortion care, with a discriminatory, disproportionate impact of restrictive abortion laws on poor, rural women.[31] The denial of safe abortion or the penalization of abortion have also been deemed to, in certain circumstances, constitute a violation of the right to be free from torture and cruel, inhuman and degrading treatment.[32]

27. According to WHO, the degree of legal access to abortion co-determines the frequency and related mortality of unsafe abortions, and evidence shows that women who seek abortion do so regardless of legal restrictions. Where there are few restrictions on the availability of safe abortion, deaths and injuries are significantly reduced.

28. According to the Special Rapporteur on violence against women, its causes and consequences, the absolute prohibition of abortion is an example of how State action can lead to violence against women and have a direct impact on maternal mortality and morbidity, as well as teenage suicides. Women and girls who are forced to continue with unwanted pregnancies commonly face re-victimization by family and society. In cases of pregnancies resulting from rape or incest, women and girls often resort to unsafe and clandestine abortion practices, sometimes with fatal consequences. In some cases, women who have suffered miscarriages or have had complicated deliveries resulting in the death of the child have automatically been accused of homicide and penalized under criminal law.[33]

29. When practiced by skilled medical professionals in a safe environment, abortion poses very little risk to a woman's life and health. The obligations of the State include that

[28] WHO, "Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008", sixth ed., pp. 1 and 5. Available from http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf.
[29] Ibid., p. 14.
[30] See E/C.12/1/Add.66, E/C.12/PRY/CO/3 and CRC/C/15/Add.107.
[31] See CCPR/CO/70/ARG.
[32] See CCPR/C/79/Add.72, para. 15; CCPR/CO/70/PER, para. 20; and CCPR/CO/82/MAR, para. 29. See also CCPR/CO/79/LKA, para. 12 and CAT/C/CR/32/5, para. 6 (j).
[33] A/HRC/17/26/Add.2, paras. 65-68.

of ensuring that adolescent girls and women are not forced to resort to unsafe abortion.[34] Ensuring contraception and access to safe abortion and post-abortion care will reduce the need for women to seek unsafe abortions. In particular, access to contraceptive goods and services, and comprehensive, evidence-based information about them, are essential to avoid unwanted pregnancies but do not preclude the need for the provision of safe abortion services. Annually, it is estimated that 33 million unintended pregnancies occur owing to failures in contraceptive methods. Women who experience contraceptive failures, for example, need access to safe services. According to WHO, the numbers of unsafe abortions are likely to continue to increase unless women's access to safe abortion and contraception are put in place and strengthened.[35] Regardless of the legality of abortion, humane post-abortion services must be provided, including guidance on contraceptive methods to avoid unwanted pregnancies.

30. A human rights-based approach implies that States must take steps to eliminate such barriers to the provision of abortion services and that lead women to resort to unsafe abortions, including eliminating unacceptable delays in providing medical attention; the existence of laws that require health personnel to report women who undergo abortion; and requirements for third-party consent for a woman to obtain abortion, even when her life is in danger. They must organize health services so that the exercise of conscientious objection by health professionals does not prevent women from obtaining access to health services.

E. Improved monitoring and evaluation

31. Accountability is at the core of the enjoyment of all human rights, and has two main components: (a) addressing past grievances; and (b) correcting systematic failure to prevent future violations. Accountability determines what is working (so it can be repeated) and what is not (so it can be adjusted).[36] The absence of human rights-based accountability mechanisms for maternal deaths and disability caused by health system failures, socio-economic disparities and discriminatory social practices is a major impediment to reducing maternal mortality and morbidity.

32. When States implement a national public health strategy and plan of action, they should also develop appropriate indicators to monitor progress made, and to highlight where policy adjustments may be needed.[37] Monitoring helps States to understand the problems and shortcomings encountered in realizing rights, providing them with the framework within which more appropriate policies can be devised.[38] States should establish accessible, effective, independent and transparent accountability mechanisms at the national level, operating in public and private sectors, constantly improving existing programmes and policies to ensure redress and reparations when pregnancy-related violations occur.

33. 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 and a system of maternal death audits in order to determine why deaths occurred. Such maternal

[34] Including by ensuring family planning, pre-and post-natal care, skilled delivery and emergency obstetric care. See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 14; Committee on the Elimination of Discrimination against Women, general recommendation No. 24, para. 27; and Maputo Protocol, art. 14, para. 2. See also A/HRC/14/39, para. 25.
[35] WHO, "Unsafe abortion" (see footnote 28), p. 1.
[36] A/HRC/4/28, para. 46.
[37] Ibid., para. 28 (e).
[38] Committee on Economic, Social and Cultural Rights, general comment No. 1, para. 8.

death audits 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.[39]

34. Accountability is the cornerstone of the Global Strategy for Women's and Children's Health, which calls on all stakeholders to support improved monitoring and evaluation to ensure the accountability of all actors for results. The Commission established to provide oversight of the Strategy proposes a "monitor-review-act" framework for accountability.[40] In order to fulfil their human rights commitments made at the High-level Plenary Meeting on the Millennium Development Goals,[41] States must ensure that their national accountability mechanisms are consistent with their human rights treaty obligations. Human right mechanisms such as the universal periodic review, the treaty bodies and regional mechanisms are crucial to a comprehensive accountability framework.

IV. Examples

35. The most effective examples involve the combination of sustained efforts to address the underlying causes of maternal mortality and morbidity while strengthening Government commitments to ensuring better access to quality health care and fostering the empowerment of women. The examples below have produced demonstrable results at reducing maternal mortality and morbidity by giving effect, to varying degrees and in different ways, to certain principles of a human rights-based approach: equality and non-discrimination, participation, transparency, empowerment, sustainability, accountability and international cooperation. These examples do not review the overall human rights situation in each State, especially in relation to women or girls, nor do they provide a comprehensive human rights evaluation of maternal mortality reduction programmes or seek to evaluate whether all aspects of these are consistent with a human rights-based approach. As seen above, standards are well developed by international human rights bodies and all States can improve their efforts to implement these norms and standards and to adopt an integrated human rights-based approach to preventable maternal mortality and morbidity. The examples below give effect to certain principles of such an approach, but are not cited as examples of a holistic and comprehensive approach to maternal mortality and morbidity. The fact that few examples of how the human rights principles of sustainability and transparency exist is evidence of how much more needs to be done. While some excellent examples of mechanisms have been outlined, they also demonstrate the need to incorporate further, through consistent and systematic efforts, other human rights principles into strategies if they are to be considered in line with a human rights-based approach.

A. Africa

1. Efforts to abandon female genital mutilation and cutting

36. Throughout Africa, UNICEF and UNFPA have been working with Governments and partners to address female genital mutilation and cutting, using an approach that does not focus on individual behaviour but instead supports discussions and debates regarding the issue and human rights principles; for example, the Saleema campaign in the Sudan involves and mobilizes communities, religious leaders and families using mass media to spread its message as widely as possible. This human rights-based approach has resulted in

[39] A/HRC/7/11/Add.4, para. 16.

[40] Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results: Final Report*, 2011.

[41] See General Assembly resolution 65/1.

a significant rate of abandonment of mutilation and cutting at scale in a number of countries, including Burkina Faso, Djibouti, Egypt, Eritrea, the Gambia, Guinea, Guinea-Bissau, Kenya, Senegal and Uganda.

37. The approach recognizes that mothers do not have their daughters cut with the intent to harm but to secure their marriage ability and the honour of the family. It also recognizes that the practice persists because of a social norm whereby people's behaviours are conditioned by the behaviour of others and encourages communities to decide themselves to end the practice. Fundamental issues, including gender inequality, are raised, which lead to other positive results in terms of the status of women. Similar initiatives could more fully give effect to a human rights-based approach by understanding and appreciating the social dynamics behind harmful practices and empowering people to abandon them rather than passing a negative judgement on individuals and communities upholding these practices.

2. Programmes to engage men as partners in healthy sexual relationships

38. The International Planned Parenthood Federation implements programmes to engage young men in promoting gender equality through acknowledging that men can promote safer sexual practices and support their partner in healthy pregnancy and safe delivery. Such programmes have a strong influence on maternal health outcomes: young women able to negotiate condom use with their partner can better protect themselves against unwanted pregnancies, sexually-transmitted infections and HIV. Male partners who are engaged in these issues often provide better support during pregnancy and childbirth and are less likely to be violent towards women during pregnancy.

3. Maternal death reviews

39. Since 2003, UNFPA, UNICEF and WHO and other development partners have been supporting African ministries of health to institutionalize maternal death reviews. Five methods were introduced: verbal autopsy, facility-based reviews, near-miss review of severe morbidity, confidential enquiries into maternal deaths and criterion-based clinical audits.[42]

40. Overall, the development of national policies and guidelines for maternal death reviews has significantly improved, particularly in Comoros, Lesotho, Malawi, Namibia, Rwanda and Uganda. By 2010, 65 per cent of African countries reported that maternal deaths were reviewed and analysed.[43]

41. Similar initiatives to institutionalize maternal death reviews could give effect more fully to a human rights-based approach by involving communities in the planning, design, implementation, monitoring and evaluation to inform and ensure ownership of the design; expanding coverage from pilot to district to national scale, ensuring dissemination of the guidelines and programme support at the provincial and district levels; and establishing an active advocacy group at the national level to ensure civil society engagement and to build capacity. A specific budget line for the review in the health sector helps to ensure it is not lost among competing priorities.

42. Egypt has integrated child health and family planning programmes, upgraded facilities to strengthen safe motherhood programmes, combined oral rehydration programmes with the expansion of water and sanitation systems, and trained health-care workers in parallel with community outreach programmes in order to be on track to reach Millennium Development Goals 4 and 5.

[42] WHO, *Beyond the Numbers*, Geneva, 2004.
[43] UNFPA submission.

43. The National Human Rights Commission of Kenya shows the role that quasi judicial bodies can play in ensuring Government accountability for maternal health. The Commission initiated a public inquiry into reproductive health care, providing a forum for the discussion of reproductive health services; to identify root causes of poor quality and inadequate services; to establish causes for high rates of maternal mortality and to find practical solutions; provide victims with an opportunity to express their opinions; raise public awareness, promote public debate; and make recommendations.[44]

44. The Government of Malawi and its partners have a sector-wide approach funding mechanism whereby annual planning is undertaken with all stakeholders, avoiding duplications and reducing dependency on single donors, helping to achieve a 44 per cent drop in its maternal mortality rate between 1990 and 2008.

45. Community-based health surveillance assistants, employed and trained by the Ministry of Health, undertake outreach in communities, register pregnancies, carry out maternal health audits and verbal autopsies, and address young people's sexual and reproductive health issues. Interventions at the community level focus on the monitoring of maternal deaths and promoting community participation by establishing audit committees and advocating local authorities (through meetings for community leaders and chiefs and popular theatrical performances).

46. Improved accountability has been instrumental in Rwanda. In 2008, the Government, with UNFPA support, adopted a strategy that includes maternal death reviews, using facility-based death audits, confidential enquiries into maternal deaths, and verbal autopsies. Delegations of local community leaders conduct investigations, which the Government then monitors. Reproductive health, including family planning, has been prioritized, and Government ministries are required to have women-centred plans of action and gender budgeting. The health system has been strengthened through innovative programmes to train and retain new health workers, and international assistance. Joint UNICEF/UNFPA/WHO support has increased local resource mobilization, improved family planning services at the community level, provided ambulances and piloting a rapid text message service, which has empowered community health workers in one district with a telephone that allows them to respond quickly.[45]

47. In Sierra Leone, the free health care service scheme, funded mainly by the British Department for International Development, aims to increase access to health care for 230,000 pregnant women by removing user fees and graduated improvement in the quality of services provided.[46] Food support for pregnant women is given by WFP in some clinics, and the Ministry of Health has nutritionists in each district to advise pregnant and lactating mothers.

48. UNICEF and the Liverpool School of Tropical Medicine are implementing an innovative competency-based training programme for health personnel using mannequins to train health professionals in just four days (rather than the usual 10). This approach is ideal for countries where there is an urgent need to address a lack of skills among health workers, where the case load may not be sufficient or the overall human resources may not exist to support competency-based training.

[44] Federation of Women Lawyers Kenya and Center for Reproductive Rights, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* (2007) (Center for Reproductive Rights submission).
[45] UNFPA submission.
[46] See http://projects.dfid.gov.uk/project.aspx?Project=201853.

49. Action Aid and Marie Stopes implement a human rights-based approach programme focusing on rural women, by empowering them about sexual and reproductive rights; training traditional birth attendants as community health workers and supporting mobile outreach clinics; using the media to increase awareness of the Government's free health-care scheme; and establishing women's forums in local communities to be active in monitoring access to health services and cases of violence against women.

50. In the remote west of the United Republic of Tanzania, Pathfinder International and the Women's Refugee Commission have worked to reduce maternal deaths caused by post-partum haemorrhaging in internally displaced and refugee populations. They have developed an innovative model that guides stakeholders at the national, facility and community levels in addressing the underlying causes. This model combines community engagement with clinical interventions and Government advocacy. Pathfinder International is also pioneering new life-saving technologies, such as a non-pneumatic anti-shock garment that allows women to be stabilized and transported long distances, thus extending essential services to women in poor, rural underserved areas.

B. Asia

51. In Bangladesh, the status of women and maternal mortality and morbidity were addressed at the national policy level as human rights and prioritized in 1990;[47] since then, the role of husbands, family and community are recognized as being essential to improve maternal health and, as a result, strategies to improve community engagement were developed.[48] The Community Support Systems initiative mobilizes and empowers by educating women and their families. They have identified several ways to decrease delays in getting to services that provide emergency obstetric care. Antenatal check-ups, deliveries by skilled birth attendants and referral for complications have increased.

52. In Tamil Nadu in southern India, there has been significant progress towards Millennium Development Goal 5 owing to improved literacy, reduced incidence of early marriage, early pregnancy and frequent pregnancies, and greater public awareness of family planning and good nutrition. These advances were also due to social reform and political commitment to improve maternal and newborn health and to establish women-centred health policies.[49]

53. The reductions in maternal mortality were achieved through a three-pronged strategy: (a) prevention and termination of unwanted pregnancies; (b) accessible high-quality antenatal care and institutional childbirth, with routine essential obstetric care and emergency obstetric first aid at the primary level; and (c) accessible high-quality emergency obstetric care at the first referral level.[50]

54. Quality of services was addressed through initiatives to create a more welcoming environment, including tours of the facility; a birth companionship programme to encourage women to have support during labour and childbirth; and Valaikappus ceremonies held in primary health centres to integrate tradition and culture into service provision. Community leaders and village officials were brought together to participate in the planning and implementation of health programmes. Finally, street theatre has been

[47] UNICEF submission.
[48] Ibid.
[49] WHO, *Safer Pregnancy in Tamil Nadu: from vision to reality*, New Delhi, WHO Regional Office for South-East Asia, 2009; Office of the Registrar General, India. Special bulletin on maternal mortality in India 2004-06: sample registration system.
[50] WHO submission.

used to explore the issues of dowries, early marriage, violence against women, maternal mortality and morbidity and gender equality in decision-making.

55. Ensuring accountability is another important strategy used in India. Advocates in domestic courts have successfully drawn on constitutional and human rights law to argue that the State is not fulfilling its legal obligations to prevent maternal mortality and morbidity.[51] For example, in the 2010 decision of *Laxmi Mandal v Deen Dayal Hari Nager Hospital & Ors*, the Delhi High Court recognized a constitutionally protected right to maternal health care and ordered compensation for human rights violations experienced by two impoverished women who died during childbirth. The High Court recognized the State's failure to implement various programmes to reduce maternal mortality and infant mortality and directed it to remedy deficiencies in, and improve monitoring of, public health programmes.

56. *Snehelata "Salenta" Singh v. The State of Uttar Pradesh & Ors* is the first known public interest case filed with a high court to deal with pregnancy-related morbidity. Salenta Singh suffered a debilitating injury after she went to a public hospital in Uttar Pradesh to give birth, where she was left alone while in labour. Owing to the poor quality of care provided, she developed an obstetric fistula. Her situation worsened when her condition went undiagnosed and then untreated for months. The lawsuit argues that pregnancy-related injury and illness resulting from medical negligence violates a woman's right to live with dignity and her right to health – rights that are recognized by both the Constitution and international human rights treaties that India has ratified.[52] These are two examples of legal remedies to assist in ensuring accountability for violations of human rights in the context of maternal mortality and morbidity.

57. Despite many efforts, the maternal mortality rate in the Lao People's Democratic Republic remains high,[53] and infant and maternal mortality rates among ethnic minorities are higher than national averages. In 2007, UNFPA supported a qualitative research study using the Participatory Ethnographic Evaluation and Research (PEER) approach, a methodology particularly suitable for gathering data from hard-to-reach, illiterate people. The study explored reproductive health among vulnerable ethnic communities and provided detailed qualitative data on risk factors relating to maternal health and barriers of access to service. As a result, among other initiatives, community representatives are responsible for providing feedback to service providers and helping to address linguistic and cultural misunderstandings.

58. The Vietnam Family Planning Association operates an outreach project in more than 100 secondary schools, delivering youth-friendly services to all students who want them. They provide information about sex, sexual and reproductive health, counselling, contraception, testing for sexually-transmitted infections, and referrals. The Association also trains young people to deliver education to their peers. By having access to services, and as peer educators, young people are empowered and their knowledge improved. The Association's experiences were shared with other co-organizations, helping others to refine their youth-friendly services and outreach initiatives.

[51] The Center for Reproductive Rights partnered with the Human Rights Law Network, an Indian non-governmental organization, to develop a litigation strategy around maternal mortality and morbidity in India.

[52] See http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Salenta_v_UP.pdf.

[53] 405 per 100,000 live births in 2005 (UNFPA submission).

C. Eastern Europe

59. In Armenia, sexual and reproductive health education is included in the school curriculum for eighth and ninth grades as part of a healthy lifestyle course; since 2010, with UNFPA support, sexual and reproductive health is also integrated into tenth and eleventh grades. Since 2005, there has not been a single maternal death due to unsafe abortion.

60. UNFPA has provided support for the establishment of travelling gynaecologist and emergency obstetric care teams for hard-to-reach and poor areas,[54] as barriers to health-care access primarily include poverty and geography, with many women experiencing challenges associated with cost and availability of transport.

61. In the Republic of Moldova, the "Beyond the Numbers" programme focused on near-miss case reviews in referral-level facilities and confidential enquiries into maternal death at the national level. Together with ongoing maternal death audits, this has helped identify the causes of maternal mortality and morbidity, including such socio-economic factors as migratory lifestyle and rural residency.

62. In 2005, a strategic assessment of policies and quality of services for contraception and abortion care revealed disparities between institutions and service providers. Since 2009, contraception costs are covered for women who cannot otherwise afford services, and national standards for safe abortion have been developed. Medication for medical abortions were registered in 2000 on the national list for essential medicines.

D. Latin America

63. Bolivia (Plurinational State of) has established cultural protocols for motherhood and newborn care, and created a model in July 2008 aimed at reinvigorating native indigenous rural medicine and ensuring its linkage and complementarity with Western medicine. It is intended to provide health services that take the person, family and the community into consideration by accepting, respecting, appraising and articulating indigenous rural people's biomedical and traditional health knowledge. Working with local actors and interacting with representatives of the community is a key requirement of the model.[55]

64. In Brazil, a legislative investigation commission was created specifically to investigate maternal mortality. It explicitly made references to human rights principles and norms, international conferences and human rights treaties.[56] The commission acknowledged that the devaluation of women in society, poverty and women's lack of access to education and justice were central factors contributing to the high rate or maternal mortality. The commission made many recommendations, including to the Ministry of Health, for the establishment of maternal mortality committees and to give priority to family-planning programmes to prevent unsafe abortion.

65. Enhanced legal accountability was sought through the case of *Alyne da Silva Pimental v Brazil* filed before the Committee on the Elimination of Discrimination against Women.[57] The applicants alleged that the failure by Brazil to provide maternal health care violated several of its international obligations. The Committee was asked to direct Brazil to prioritize maternal mortality reduction, including by training providers, establishing and

[54] UNFPA submission.
[55] Ibid.
[56] IPAS Brazil submission.
[57] Center for Reproductive Rights and Citizens' Advocacy for Human Rights.

enforcing protocols and improving care in vulnerable communities. This case, still pending, is the first individual communication on maternal mortality filed before a United Nations treaty body and is part of a strategy to ensure that rights-holders have access to international mechanisms when domestic remedies fail.

66. In Chile, the UNICEF guide *Growing together* was prepared, in partnership with local stakeholders, to assist Mapuche indigenous women during pregnancy and childbirth who face inequality and discrimination in their access to health care.[58] The guide highlights Mapuche customs relating to maternal health and contains relevant information for daily practices for pregnant women and their families.

67. In 2008 and 2009, two non-governmental organizations partnered with health rights activists to develop a rights-based framework for holding the Government accountable for, inter alia, the high rates of maternal death and for its failure to use its resources to fulfil progressively the rights to reproductive health.[59] The strategy aimed at (a) articulating the human rights obligations that should guide maternal mortality prevention efforts; (b) showing how the State's maternal health interventions and fiscal policies were falling short of these; and (c) pushing for specific measures to bring health, budget and tax policy into line with human rights standards in the context of the Government's ongoing health reforms and the 2010 budget process. A compelling picture of non-compliance emerged and detailed recommendations were made to the Government on the need for increased, equitable spending on maternal health. Specific budget and tax reforms, as well as enhancing citizen participation in the decision-making process, were also recommended.

68. The project forced institutions in Guatemala to bring a human rights-based approach to policy-making and monitoring. It succeeded in linking fiscal policy and preventable maternal mortality and morbidity and drawing the attention of United Nations treaty bodies, including the Committee on the Elimination of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee. It prompted a commitment to increase social spending for maternal health, and to implement the necessary fiscal reforms to enable this. It also enabled a joint congressional and civil society accountability mechanism to operationalize a human rights-based approach in their policy monitoring role at both the national and local levels. The monitoring framework has also been welcomed by donors and United Nations specialized agencies in the context of monitoring progress on Millennium Development Goal 5.

69. In Haiti, a Government-led project, supported by the Canadian International Development Agency, the Pan American Health Organization and the EC/ACP/WHO Partnership (a tripartite agreement signed by the European Community, African, Caribbean and Pacific Island countries and WHO, as well as by national ministries of eight countries, including Haiti, to support Millennium Development Goal 5), provided payment to 50 health institutions to offer pregnancy, childbirth and post-partum/post-natal care. Women are also reimbursed for their transport costs, and payments are made to traditional birth attendants. The system is also used to monitor performance. The project supports the rehabilitation of health institutions, purchase of equipment, training of providers and provision of supplies and essential drugs. In some areas, community members have been recruited and trained to support women. These community agents also serve on maternal mortality surveillance committees, referring women with potential complications and conveying feedback to hospitals. As a result, a decline in maternal deaths, a six-fold

[58] UNICEF submission.

[59] Center for Economic and Social Rights and Instituto Centroamericano de Estudios Fiscales, *Rights or Privileges? Fiscal commitment to the rights to health, food and education in Guatemala*, 2009.

increase in the use of antenatal care, and a 62 per cent increase in institutional childbirths was reported.

70. In 2007, the Mexico City Federal District reformed its Penal Code to permit legal abortion in the first trimester of pregnancy. Whereas adolescent and adult women previously sought expensive clandestine abortions in the District, today public hospitals and clinics provide women residing in the district with free and safe legal abortion care; women from other parts of the country can also receive services according to a sliding payment scale.[60]

71. In the 2009 case of *Xákmok Kásek Indigenous Community v Paraguay*, the Inter-American Court of Human Rights found human rights violations where the absence of special measures to protect pregnant women contributed to the pregnancy-related deaths of indigenous women. The Court rebuked Paraguay for it failure to implement policies to train skilled birth attendants, provide pregnancy-related care and document cases of maternal mortality. It ordered the State to establish immediate measures to provide health care for pregnant women and directed it to conduct a study with community involvement, identifying means for adapting maternal care to community needs. The Court mandated broad stakeholder participation in developing policies to combat maternal death.

72. In Peru, the Vertical Childbirth Care/Delivery project supported by UNICEF aims to increase access to institutionalized services for indigenous pregnant women. An integrated strategy was developed to address the financial, geographical and cultural barriers that historically limited the access of rural and indigenous communities to health care.[61] Financial barriers were addressed by creating a health insurance strategy and providing subsidies for individuals under the age of 18, pregnant women and targeted groups of adults. To address geographical distances, maternal waiting homes were established and services were adapted to users' cultural preferences regarding childbirth.

73. Similar initiatives could give effect more fully to a human rights-based approach by targeting women and girls most at risk, involving indigenous local leaders, traditional care providers and community women's organizations in identifying the required interventions to increase utilization of health services, as well as ensuring culturally appropriate care for indigenous communities and seeking an alternative and more acceptable model.

74. The Ombudsman of Peru also has a dedicated women's rights unit to investigate and document complaints against health-care centres and hospitals for irregularities; for example, it has investigated violations of the right to contraceptive services free from coercion.[62]

V. Conclusions

75. The present report has identified key interventions known to reduce maternal mortality and morbidity. The examples demonstrate that interventions are more effective when stakeholders apply principles of a human rights-based approach to address the needs of the most poor and marginalized in their societies. They also demonstrate the need to incorporate fully, through consistent and systematic actions, an even more holistic and comprehensive human rights-based approach, covering all seven principles, into integrated strategies to combat maternal mortality and morbidity. Strong community-based efforts hold Governments and other actors

[60] IPAS USA submission.
[61] UNICEF submission.
[62] Center for Reproductive Rights submission.

accountable for delivering on their commitments and ensure that money invested in the maternal health sector is used in a transparent and sustainable manner.