COMBATING MATERNAL MORTALITY: WHY BRING HUMAN RIGHTS INTO THE PICTURE?

A Panel of International and National Experts

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NGO Side-Event♦

Moderator: Melinda Ching-Simon, Women's Rights and Gender Unit, OHCHR

Speakers:
- Anand Grover, UN Special Rapporteur on the Right to Health
- Ariel Frisancho, International Initiative on Maternal Mortality and Human Rights
- Soyata Maiga, Special Rapporteur on the Rights of Women in Africa
- Maha Muna, Humanitarian Response Branch (Geneva), UNFPA

SANDEEP PRASAD – (Action Canada for Population and Development)

I would like to welcome everyone and thank the moderator and panelists for attending this panel.

MELINDA CHING-SIMON – (Women's Rights and Gender Unit, OHCHR)

Paul Hunt, the former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health had spearheaded efforts to renew global attention to the problems of maternal mortality and morbidity. The first dialogue on maternal mortality by the Human Rights Council (HRC) in June 2008 and in the same year, the statement signed by 85 governments both served as a reaffirmation that maternal mortality is a human rights issue. I would like to pose the following questions to the panelists and for general discussion: how is maternal mortality a human rights issue? How can the human rights framework be applied to address the problem? And what can the HRC do?

On that note, I would like to introduce the first speaker, Anand Grover and invite him to speak.

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ANAND GROVER – (UN SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH)

The extent of the problem is very acute, figures are 0.5 million annually and increasing. This is a very serious problem, even more than HIV, which I've worked on extensively. Serious action has not been taken on this issue yet and I hope that governments and others will do so.

I would like to talk about the right to health and the human rights law framework. Over the last 3 decades, a lot of countries have not incorporated the right to the health in different formats into domestic law. Therefore, the right to health must be incorporated on the domestic level; it is part of the right to life– a fundamental right and which has been more successfully incorporated into domestic law. That understanding is important for countries where international instruments are not domesticated. For India for example, the interlink between the right to health and right to life has allowed for domestic litigation. If a woman does not get adequate pregnancy and abortion services, it is an issue of her right to life. Maternal death is directly connected to the right to life which is enforceable in law. Many emphasize only international law, but domestic law has taken over enforceability.

Elements of the right to health include the provision of all services, family planning, pre- and post-natal care, information, emergency obstetric care, etc. The 'right to the highest standard of health' in human rights law incorporates the old doctrine of "progressive realization." This is *not* applicable at the domestic level in terms of the right to health. Services have to be provided and improved, thus there must be indicators to monitor. States have the obligation to make available the *maximum* resources.

Certain features of the right to health are not subject to "progressive realization." For example, non-discrimination, which must be respected immediately; accessibility (physically, geographically, economically), availability, acceptability (respecting culture and medical ethics) and good quality of services. States cannot interfere directly or indirectly with that. For example, where abortion is legal and vigilante groups try to enforce that and demonstrate and dissuade women from obtaining abortions, it is the duty of the state to ensure that safe and legal abortion is accessible. It is a duty to fulfill this right through appropriate measures (legislative, judicial etc). The right to health framework is not always directly applicable, but also involves underlying determinants (for example, nutrition, food and water) and social determinants (for example, gender equality, autonomy and social inclusion).

The right to health and within that, non-discrimination, also implie the participation of local communities in various spheres, from decision-making to implementing, monitoring and accountability. International cooperation is also necessary.

A number of Treaty Monitoring Bodies have taken up this issue, particularly CEDAW, asserting that there must be provision of pre- and post-natal care, access to information, adequate nutrition, etc. The CEDAW, CRC, the Human Rights Committee of the CCPR, CESCR, CERD have also dealt with this.

The ‘right to health’ is slightly different than a ‘rights-based approach’. The latter involves empowering communities to achieve their right to health. Many argue that there is no evidence to support the rights-based approach. But there exists evidence that the rights-based approach works. An example is that of the sex workers in Calcutta, empowered to protect themselves and use condoms, where STD rates decreased from 25% to almost nothing.

As the international community and human rights community, we have the obligation to improve the situation. MDG 5 on universal access to reproductive health by 2015 is an existing obligation towards which little progress has been made, showing the need to take the issue head on. I welcome the HRC resolution on preventable maternal mortality, as it is imperative to support his work.

ARIEL FRISANCHO – (REPRESENTATIVE OF THE INTERNATIONAL INITIATIVE ON MATERNAL MORTALITY AND HUMAN RIGHTS)

The International Initiative on Maternal Mortality and Human Rights (IIMMHR) is a collaboration of regional and national civil society organizations committed to a comprehensive human rights approach to maternal mortality. This human rights approach includes a call for greater political will on behalf of governments and donors to take the necessary steps to reduce maternal mortality, and in turn, more effective accountability mechanisms to ensure that women's right to maternal health becomes a reality.

During my presentation, I will discuss why maternal mortality is a human rights issue, how to incorporate rights-based approaches to maternal mortality, and how the HRC can contribute to existing initiatives to reduce maternal mortality.

Maternal mortality is a human rights issue. Underlying the systemic failure to prevent maternal death is, depending on specific circumstances, is the denial of the right to health, to equality and non-discrimination, to reproductive self-determination and to the benefit of scientific progress.

Notably, trends and statistics show that we have had little success in reducing maternal mortality. In fact, MDG 5 (improve maternal health) is the least likely to be achieved by 2015. What underlies this reality are great disparities within societies. To that end, national averages often hide the true realities of maternal mortality. For example, in Peru, the national average is 185 maternal deaths for every 100,000 live births, yet when you look to the poorer regions such as in Puno or Huancavelica, extremely poor areas in the Highlands, the maternal mortality rates are 361 and 302 for every 100,000 live births, respectively. We hope that an HRC resolution regarding maternal mortality will pledge to close the disparity, not only between maternal mortality and morbidity rates in industrialized and developing countries, but also those within countries, as well as to clarify the standards and criteria that are needed to eliminate these disparities.

While there is a group of privileged people in Peru who do not face problems associated with maternal mortality because they can easily access reproductive health care, specifically emergency obstetric care, there are also extremely impoverished women who live eight to

twelve, and even more than 24 hours from the nearest health facility and the facilities available to them have inadequate supplies and human resources. To that end, three women suffer maternal death every day in Peru. These deaths could have easily been prevented through technology and knowledge sharing. We must call the governments' attention and call for transparent discussions regarding what efforts have been made and what additional efforts need to be made, to address this tragic problem. We must also put an accountability mechanism in place. Many different forms of monitoring and accountability mechanisms could exist. All mechanisms must be effective, accessible and transparent. With regard to accountability we do not mean mechanisms to simply blame and punish governments – or health professional teams - , but rather to facilitate understanding to resolve the problem of maternal mortality. We can propel this through an HRC maternal mortality resolution.

With regard to implementing a rights-based approach to maternal mortality, we need to strengthen both the demand and supply sides: we need to improve health care facilities and services, and we need to strengthen community-based organizations to consult with and educate rights-holders. The main principles to guide our actions will be participation and empowerment, promotion of accountability mechanisms and addressing unjust power relations. Even if we take measures to improve health care facilities and services, there are additional barriers that prevent women from seeking services. We need to overcome these barriers through working in conjunction with the people on the ground and holding health services accountable to serving peoples' needs. This includes possessing sensitivity for different cultures and an understanding of human rights and the human rights framework. It is important to recognize the progress that has been made thus far by governments, with the collaboration of diverse national and international development agencies and NGO. However, we must also recognize that many pitfalls still remain. In order to do that, we need to listen to the people. Sustainable, substantial change will only be achieved if poor people have greater involvement in shaping health policies and practices. IIMMHR's Field Projects in theYatta District in Kenya, Uttar Pradesh in India and Puno & Huancavelica in Peru are concrete examples on how we could do this.

On the issue of mutual accountability mechanisms, there must be accountability between donors and governments, donors and Congress, and donors and civil society. Donors and governments should promote genuine local and democratic ownership of SRH policies, in a way that the poor and marginalized are empowered and adequately represented. It is also essential that donors ensure an enabling environment to effectively reduce maternal mortality. Moreover, those affected by policies and programs must be involved in the creation of those policies and programs and in holding those in power into account.

At one point, we applied a "Three Delay" model for maternal mortality in Peru. Today, we have a deeper understanding of what leads to maternal mortality and now apply a "Five Delay" model. The five delays include: 1) the time it takes to recognize that a woman is facing a life or death health problem; 2) the decision-making time to seek services; 3) the travel-time to receive services; 4) the delay in receipt of services upon arriving at the health facility; and 5) the political delay by governments and donors in effectively addressing the issue of maternal mortality. These are the factors that we need to address today. We truly hope that government

representatives in this session will overcome that fifth delay, and join those who already support the proposed HRC resolution on maternal mortality and morbidity as a human rights issue.

SOYATA MAIGA – (SPECIAL RAPPORTEUR ON THE RIGHTS OF WOMEN IN AFRICA)

The problem of maternal mortality that we are raising today is of particular importance in the African region. Of the 500,000 maternal deaths that occur annually worldwide, more than 250,000 of those deaths occur in Africa. Pregnant women in Africa are at grave risk. Nigeria has the highest maternal mortality rate on the continent, only second to India. Additionally, there are many countries at war in Africa, which compounds pregnant women's risk, with hundreds of thousands of women dying every year.

Unfortunately, the silent tragedy of maternal mortality does not move people in our continent, where many traditions consider the death of women during childbirth as an acceptable and natural condition of women. Socio-cultural practices such as early marriage, early pregnancy, violence, female genital mutilation, marginalization in decision-making regarding issues that concern women, low status of women within the African family, and the fact that women are not enabled or permitted to plan their pregnancies - each of these factors leads to maternal mortality, an issue that can be addressed and prevented if we tackle it as a human rights issue.

The right to survive pregnancy is a fundamental human right. It involves the rights to freedom of choice in reproductive health, life, health, and non-discrimination. Each of these rights is protected under international instruments and the African Protocol on Human and People's Rights. The improvement of maternal health is a specific regional obligation under the African Women's Protocol. Moreover, in 2001, states committed to allocating 15% of governments' resources to health in the Declaration of Abuja. Within the Declaration on Equality between Men and Women, states are obligated to ensure equality between men and women, as well as ensure that women have access to family planning services and the ability to determine the number and size of their family.

States cannot violate the right to health, rather they must protect the right. They must satisfy women's health needs through undertaking positive measures to ensure access to reproductive health care and services for all women. They must also take into account cultural intricacies and women's health and nutritional needs.

Maternal mortality reflects the lack of equality between men and women. The minimum age of marriage is 15 or less in some African countries, and generally, African women are required to obey the husband, men hold all of the decision-making power, polygamy is tolerated even when prohibited by law, and African women are still seen as merely machines to make children, child-bearers. Additionally, there are still religious codes in force which do not allow women to use contraceptives and many African countries do not permit abortion. These facts are of particular concern for adolescents who have little access to sex education and fewer means to end unwanted pregnancies. In turn, adolescents resort to clandestine abortions, which lead to maternal mortality. Overarching all of this is Africans' fear of restrictive legislation, despite

ratification of CEDAW and the African Women's Protocol, which calls for access to abortion services.

Maternal mortality has become more visible over the last 20 years, but the incidence has not reduced. As such, the issue has not been given sufficient emphasis and attention, both nationally and internationally.

So what can the African Commission do? It can attempt to instill an understanding among states that they must incorporate international norms into their national legislation. It can also promote programs to improve women's health. From here, the African Commission can continue the process which began with the protocol on women's rights, an African protocol which includes right to health obligations, including adequate and accessible health services. Specifically, Article 14 addresses women's health and right to protect their reproductive health, including access to health services and to medical interruption of pregnancy when violence is involved. Article 2 requires governments to modify cultural patterns that affect women and eliminate discrimination against women.

Through the African Commission's country visits we emphasize the rights and obligations contained within the African Women's Protocol, and reference information on health service provision with respect to maternal mortality within the country reporting process. We also ask reporting countries to provide information regarding the measures undertaken to reduce maternal mortality and whether those affected are participating in the process. We do this, in part, to help NGOs working on this issue. Finally, we ask countries to adopt a human-rights approach to address maternal mortality and to include budgetary measures to reduce maternal death.
The African Commission also interacts with international NGOs working on this issue, such as the Center for Reproductive Rights, to reinforce national capacity and to make the right to health justiciable. Both NGOs and individuals have brought complaints before the Commission. In fact, all Africans can bring a complaint of women's human rights violations before the African Commission and we encourage this. We also collaborate with human rights defenders to enforce all decisions taken at the international, regional and national levels, as to ensure that maternal mortality is not a forgotten tragedy.

MAHA MUNA - (HUMANITARIAN RESPONSE BRANCH (GENEVA), UNFPA)

Maternal mortality is an important and timely topic. Women are still apprehensive about seeking medical care during pregnancy. Why? Because these services are not always culturally sensitive. For example, through a new UNFPA program that seeks to incorporate cultural needs in safer contexts 18-year-olde Maria can now give birth vertically, in her traditional manner in a hospital. This is one of many safe delivery mechanisms. There is a right to accessible, safe, culturally-sensitive reproductive health care**.**

The leading causes of maternal mortality can and should be avoided. It's time to raise the alarm. Countries with the highest rates have virtually made no progress. The UN has used its various arms to address this issue but more needs to be done. We have a number of international instruments: starting with the ICPD in 1994 and the 2000 Millennium Declaration-the MDGs

include a benchmark. In 2005 there was an acknowledgement that more needs to be done, and access to reproductive health as a target was included.

An instrumentalist approach to the issue gives us ammunition. It's an obligation to save women's lives, but it's also economically sound. Every year countries lose 15 billion dollars due to women dying or care provided due to morbidity, but it only costs 6 billion to provide proper services.

The rate of reduction in maternal mortality has only declined by 1%. The target in the ICPD requires an annual decline of 5%. Progress on MDG 5 is lagging the furthest behind. Meeting the target set in ICPD is also far behind.

It's time for the Council to join the rest of the UN bodies to reinforce the human rights dimensions of this issue. We have the HRC statement last March on maternal mortality, we know that article 12 of CEDAW requires the Special Rapporteur to ensure women appropriate services in connection with pregnancy. This is certainly an issue for the HRC.

The reduction of maternal mortality is possible. We have good examples (Cuba, Egypt, Thailand, Tunisia etc.) which have been able to reverse the rates by strengthened health care systems, and others which have halved their mortality rates with political will and adequate resources.

What does it take? Three focus areas: first of all, a recognition that giving birth safely is a human rights standard and principle which is inexpensive. Limited measures need to be taken to get there: access to contraceptives, skilled personnel and prompt emergency obstetric care. Secondly, acknowledging the challenges in addressing rights-holders which require mobilizing communities, raising awareness as well as tackling inequality and discrimination. Complications during childbirth are the leading cause of death for women in Africa and for girls 15-19 in developing countries in general. This reflects entrenched discrimination against women and failure to promote women's rights. Many women are unable to exercise their rights because of their youth, poverty and ethnic background. The link between rights-holders and duty-bearers is made through civil society. This needs a comprehensive approach that tackles also sexual violence, early child marriage etc. And finally, we need culturally-sensitive access to health care. We must bring international norms and standards to the lives of women and girls.

Morbidity is another aspect that needs to be tackled and other long-life effects of unsafe child births, including social exclusion for life-long health conditions. Those who do not die, may experience life-long disability, including fistula (leaving women incontinent and causing social death). Women are abandoned by their community and cannot live a life full of dignity and cannot access education. One million women suffer with this today, as well as uterine prolapse, chronic infertility and uterine problems.

This is where the HRC has an obligation to act: hold duty-bearers accountable and ensure that rights-bearers can exercise their rights.

QUESTIONS AND ANSWERS

Amy Laurenson - New Zealand delegate sponsoring the HRC resolution: *Strategy at the UNHRC*

We are trying to push for a HRC resolution through the assistance and work of civil society. One of the obstacles we face at the HRC is a lack of awareness regarding maternal mortaliy and that countries still do not perceive it as a human rights issue. The number of initiatives already under way are extremely important, there are great developments in African and Latin America. In terms of taking the idea forward, it is very important in the next 18 months to conceptualize exactly *what* the HRC can do. We don't want them to duplicate efforts and make states feel pulled in different directions. Therefore our approach started with the recognition that it's a human rights issue which was the aim of resolution. This is to be followed with consolidating the information available to draft a thematic study to clearly draw out the human rights implications of maternal mortality and determine exactly what the HRC can do. We want to collect data from WHO, UNFPA, and others who have been working on this. We hope the speakers can contribute to this process. We apologize for the ignorance of people at the HRC (for example, some delegates do not know what morbidity is). This will be a slow process of raising awareness. We should provide copies of the presentations to deliver to the delegates to enlighten them better.

Fernando Munoz – Ministry of Chile (Health Attaché): *How do we further improve national efforts by utilizing a rights-based approach?*

A rights-based approach can help introduce this as a priority and at the end, we will be measuring the success of the human rights-based approach in terms of the results achieved. The most important existing commitments are the MDGs and MDG 5 is FAR from being reached. We have been working on this for 10 years and we have not been doing as much as we could do. A human-rights based approach could help us to introduce a real priority in terms of MDGs. When you establish a real priority, you are establishing a goal that you agree to put in a different hierarchy than other problems. For example, WHO assemblies have a resolution on monitoring the achievements of MDGs related to health, but also have hierarchies. Maternal mortality or MDGs related to health are a step before doing other things, they must be a real political priority and they are not. If they were a priority, then there should be more efforts in collaboration between countries at the international level. We already know the factors, but the way these factors relate to each other varies according to which countries need further work. We need to look at the reasons we are not reaching the goals in each country-specific context. We should challenge ourselves in a new trend, even though we will not reach the goals in 2015.

Anand Grover's Response – It definitely isn't a priority for states, but how do we make it as such? You need community pressure from below. The most important thing is to make maternal mortality a priority. The problem is that governments don't see health as a priority at all, and even less because it's a problem that affects women. We can change this through community pressure from below. But people themselves do not consider this a priority. Indian women's NGOs will address violence against women, but not maternal mortality. People at the UN need to push it so it's an issue at the local level – we need people at the local level to raise their voices. If it's a rights-based issue, it's an entitlement issue. It must be seen as

"unacceptable" so that it can become a priority. The fact that women die is just ACCEPTED – this is the saddest thing.

Ariel's Response – There's a lot to be done. We believe the Council's involvement on this issue will be a good display of the governments' commitment to tackle maternal mortality from a human rights perspective. There is a momentum for maternal health currently and the HRC's resolution will be an important signal of inter-governmental agreement on this issue, and could leave to real priorities and effective resource allocation We have a problem with health priorities, especially priorities of the poor and excluded: In Peru, everyone is aware of EVERY case of swine flu, but two weeks ago 147 died from the normal flu in the Highlands (same season each year) and no one paid attention. This is a problem of discrimination. People are afraid to call this as a human rights violation, but we need to use those words to bring urgency. We cannot live with such big gaps of injustice. We need new human rights language to address this. People are afraid of talking about social rights in Peru, as if they were different, lesser rights than civil and political rights. We would not accept – not even imagine - to cancel elections because of no available resources, but we do accept women dying in pregnancy because there is "no money." You can't blame the lack of resources to justify the deaths of mothers, especially when we know what it takes to help women have safe pregnancies.

Soyata Maiga's Response – This is an avoidable tragedy, but in Africa we feel despair because there are so many other inter-related factors: bad governance, unstable political conditions and conflict and the African political community has not managed to find the right path to enforce human rights. Resources also remain dedicated to economic development and which was made worse by the financial crisis. Women suffer the most. Women do not go to the health center because they're too far and doctors don't speak our language and in our culture, women cannot take their clothes off in front of men who are not their husbands. Populations want to live their traditional ways of life. For indigenous populations, you must see where they are, what they need, etc. There are simple steps that can be taken, you have to approach communities and see how they can adopt safe birth conditions to them. We have the highest rate of maternal morality, but no one is doing anything about it. There is too little money for what is needed. Women themselves must be educated and know their rights to call for respect of their rights. But even literate women need assistance to access litigation.

Ignacio Saiz – Center for Economic, Social and Cultural Rights: *Minimum Core Obligations*

In terms of framing legal arguments, where I work we place a lot of emphasis on ensuring that reproductive health is a core obligation as reiterated and expanded by the CESR. The notion of "core obligation" enables you to bypass the notion of "progressive realization." This can enable you to make the argument that ensuring availability, accessibility and acceptability should not be as resource dependent. This is an allocation issue. All governments are bound to provide minimum essential levels, both in terms of outcomes, but also minimum essential levels of policy changes (*i.e.*, ensuring access to EOC, skilled birth attendants *etc*). The notion of "core obligations" requires international cooperation, particularly when developing countries cannot

even meet their minimum obligations. Focus on “core obligation” can help us build political priority.

Anand Grover’s Response – If you use “core obligation” you will lose at the domestic level. It's an important argument, you can use this in terms of monitoring, but as a legally enforceable argument it is not used at the local/national level. The only obligation at the international level is the TRIPS agreement, the decisions of the Human Rights Committee are not enforceable. When talking about an “obligation” it must be enforceable. It was rejected by the South African High Court. It's dangerous at the local level if you argue one thing is a “core obligation” and another thing is not. Paul Hunt's report on maternal mortality touches upon that. It's an important argument to develop.

Ariel Frisancho’s Response – When we talk about human rights we should also talk about indicators and benchmarks: trying to operationalize the entitlements and the guarantees**.** We also have standards on health care: available, accessibility, acceptability and quality, which we need to transform into obligations and explicit guarantees. We need to work with explicit guarantees known by the people and the providers. And guaranteed by the government, with close monitoring and surveillance by informed, empowered civil society and grass-roots organizations.

Melinda Ching-Simon – Closing:

Philip Alston at the full day discussion on the human rights of women mentioned that a mission in Geneva called upon him to address “honor crimes.” He said that if “one or two deaths a year happened due to honor crimes, this would just be murder, but if there were hundreds or thousands of deaths occurring, a due diligence obligation comes into play.” It's probably good to use this analogy.

In conclusion, all speakers agree it's a global emergency, but Maha also added the economic cost of the issue. The Special Rapporeur on health clarified what human rights elements are included and that there's a growing recognition by treaty-body mechanisms of this being a human rights issue. Strong and healthy civil society networks are essential as well as the need to close disparities between countries and within them. We were also provided by a real picture of the situation on the ground in Africa and the lead of the African Commission on this issue. All panelists emphasized the value of the Council's engagement on this issue and how to integrate a rights-based approach to it.

PANELIST BIOGRAPHIES

ANAND GROVER, is the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health. The Special Rapporteur is a practicing lawyer in the Bombay High Court and the Supreme Court of India, as well as the Director of the Lawyers Collective HIV/AIDS in India, which he co-founded with Ms. Indira Jaising.
The Special Rapporteur is a pioneer in the field of HIV and serves as a member of various renowned health boards. He has also handled several hundred HIV/AIDS related litigations in India. He argued the first HIV case relating to the HIV activist, Dominic D Souza, challenging the isolationist Goa Public Health Amendment Act. He has also argued several well known cases as lead counsel, including the first case on blood transfusion in the Calcutta High Court, the first HIV case in India relating to employment law, several environmental cases including the *Bhopal Gas Disaster* case, as well as cases dealing with sexual harassment, animal rights cases, the right to marry and the rights of sex workers. Along similar lines, the Sprecial Rapporteur drafted the HIV Bill at the request of the Government of India, with the support of the Lawyers Collective HIV/AIDS Unit.

ARIEL FRISANCHO, is the National Coordinator of CARE Peru's Health Programmatic Team and the program manager for the "Participatory Voices" Project. He is also a representative of the International Initiative for Maternal Mortality and Human Rights. Over the past twenty years, Mr. Frisancho has contributed greatly to the public and private sectors with the construction of different health policy proposals and publications, as well as the implementation of strategies oriented to equity in health services provision. He served as Executive Director of the Peruvian Ministry of Health International Co-operation Office and Project Manager of the DFID Capacity Building Project (1995-200). Mr. Frisancho has worked in the Italian & German International Co-operation in Health and Peruvian NGOs (Movimiento Manuela Ramos), and has been a consultant for Peruvian Government's Ministries Council, PAHO & British International Co-operation.

Mr. Frisancho is a medical doctor, with complete studies for Masters of Science (C*ayetano Heredia* University in Peru) on Public Health and a Masters of Science on Health Policy, Planning & Financing in the London School of Economics and the London School for Hygiene and Tropical Medicine (University of London). In 2004, he was elected member to the Directorate of ForoSalud (the most prominent civil society network in Peru) and in 2006 civil society representative at Peruvian National Health Council. Mr. Frisancho is part of CARE's maternal and newborn health (MNH) learning group and CARE's Rights-Based Approach Reference Group.

SOYATA MAIGA, is the Special Rapporteur on the Rights of Women in Africa. Prior to this post, the Special Rapporteur was an Assistant State Prosecutor for the Bamako, President of the Court of Magistrates, Head of the Civil Rights Division under the Director of Civil Affairs, President of the court of the Commune II, and the President of the Prosecutors Office in Malian Court of Appeals.

In her capacity as Expert consultant, the Special Rapporteur published several studies and report about human rights generally and, more specifically, about the rights of women in Mali and the level of integration of international human rights standards in local political and practical realms. As part of the official delegation from Mali, the Special Rapporteur has represented several NGOs concerned with women's issues at various international conferences and meetings, including: Conference on Human Rights in Vienna, 1993; Conference on Women's Rights in Beijing, 1995 ; Beijing + 5 ; and Beijing + 10. The Special Rapporteur received her diploma from the National School of Law in Paris, with a focus on International Studies, and the National School of Administration in Mali, with a focus on law, from which she d'où elle est sortie major de la promotion 1972-1976.

MAHA MUNA, works for the United Nations Population Fund (UNFPA), currently on a Capacity Building project and previously as Emergency Coordinator for UNFPA/Sudan, focusing on the humanitarian response in Darfur and in response to chronic flood emergencies in East Sudan. UNFPA/Sudan emergency reproductive health programming focused on averting maternal mortality, addressing HIV/AIDS and supporting prevention and response to gender-based violence (GBV).

Prior to joining UNFPA as Emergency Coordinator for Sudan, Maha Muna was Officer in Charge and Programme Manager at the Governance, Peace and Security unit of the United Nations Development Fund for Women (UNIFEM). Ms. Muna has also served as Deputy Director of the Women's Commission for Refugee Women and Children, and worked at the International Rescue Committee (IRC) as Country Representative for Azerbaijan, Regional Director for the Great Lakes Region and Programme Officer covering programming in the Middle East, Africa and Asia. Ms. Muna began her career at Save the Children/US as Programme Officer for Middle East and North Africa region. Ms. Muna holds a Masters in International Affairs from Columbia University, School of Public and International Affairs and a Bachelors of Arts at the University of California. She is married and has two children.