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BRIEFING PAPER

USING THE MILLENNIUM DEVELOPMENT GOALS TO REALIZE WOMEN'S REPRODUCTIVE RIGHTS

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"The Millennium Development Goals (MDGs) are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions—income poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education, and environmental sustainability. They are also basic human rights: the rights of each person on the planet to health, education, shelter, and security."[1]

1) Eradicate Extreme Poverty and Hunger
2) Achieve Universal Primary Education
3) Promote Gender Equality and Empower Women
4) Reduce Child Mortality
5) Improve Maternal Health
6) Combat HIV/AIDS, Malaria, and Other Diseases
7) Ensure Environmental Sustainability
8) Develop a Global Partnership for Development

I. Introduction

Around the world, women's health and empowerment depend on a development agenda that recognizes their needs and concerns. Such an agenda is essential for raising women's status—but not sufficient. Only when women can enjoy their human rights, including their reproductive rights, will they be able to achieve their own objectives and fully participate in every sector of society. The Millennium Development Goals (MDGs), which have energized the field of development and its international players,[2] are entirely consistent with states' human rights obligations. A clear understanding of what those obligations are will help governments maximize opportunities to advance women's human rights through their implementation of the MDGs.

The MDGs are political commitments that call specifically for the end of poverty and gender inequality, improvement of education and maternal health, and reduction of child mortality and incidence of diseases. They also promote environmental safeguarding and global development partnerships. Under each of the eight MDGs, 18 time-bound targets and 48 indicators were developed to measure progress towards attainment of the Goals. Notably, the MDGs are directed primarily toward health-related initiatives; and more recently, following the 2005 World Summit, world leaders agreed to two additional reproductive health-related targets.[3]

While the MDGs have contributed to galvanizing development agencies, national governments, nongovernmental organizations, activists, and the entire UN system, they have also been critiqued as being under inclusive by calling for narrow interventions that do not address the underlying causes of poverty and inequality, for failing to lead to long-term sustainable development,[4] and for overshadowing the rights-based Millennium Declaration.[5] Human rights advocates have also raised concern over the MDGs' use of aspirational language for goals that, in fact, implicate binding human rights obligations.[6] Along similar lines, concerns have surfaced regarding whether the MDGs sufficiently address sexual and reproductive health, despite their indispensability to human and economic development.[7]

In light of these concerns, this briefing paper brings into focus the close alignment between the MDGs and the human rights framework, and highlights the possibility of advancing reproductive rights through the MDG agenda. Specifically, the briefing paper demonstrates that while the MDGs are political commitments, they also provide advocacy opportunities and serve as important benchmarks for progress with respect to governments' human rights obligations. This is particularly important in the area of reproductive rights, which have been set forth in international human rights treaties and jurisprudence, and in the Programme of Action of the International Conference on Population and Development in Cairo (ICPD Programme of Action)[8] and the Platform for Action of the Fourth World Conference on Women in Beijing (Beijing Platform for Action).[9] It is necessary to bear in mind that governments' binding duties under international human rights law take precedence over their political commitments to fulfilling the MDGs. Nevertheless, despite the differences in the types of obligations created by the human rights framework and the MDGs, there are increasing opportunities to utilize the linkages between the two to achieve common goals.

II. The MDGs are Grounded in Human Rights Obligations

The MDGs are firmly rooted in international human rights laws. Both the Millennium Declaration adopted by 189 countries in 2000, and its road map, from which the MDG framework is derived, assert that "human rights should be at the center . . . of development programs."[10] Moreover, the UN Secretary-General confirmed in the road map that "economic, social and cultural rights are at the heart of the Millennium Development Goals."[11] The Secretary-General's statement is bolstered by the fact that the Millennium Declaration "contains twelve references to human rights and specifically situates global development in a rights-based framework" by explicitly referencing the Universal Declaration of Human Rights (Universal Declaration) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[12]

Furthermore, conceding that "women bear the disproportionate burden of global poverty[,]"[13] the Millennium Declaration also acknowledges the "equality of women and men" and emphasizes the importance of promoting gender equality to obtain sustainable development.[14]

Not only are the MDGs built upon the human rights framework, but the development agenda set forth within the MDGs incorporates sexual and reproductive health and rights, as conceived within the human rights treaties, jurisprudence and the ICPD Programme of Action and Beijing Platform for Action. It is now well-established in international human rights law that reproductive rights are human rights premised upon the fundamental rights to life, health, freedom from discrimination, self-determination, and access to information. Setting the groundwork for this recognition was the 1994 ICPD where "participating States recognized that sexual and reproductive health is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations."[15] The Programme of Action stemming from the landmark international conference defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and to its functions and processes."[16] The ICPD Programme of Action further confirms that:

> [R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[17]

In addition to providing a comprehensive definition of reproductive rights, the ICPD Programme of Action sets forth a myriad of guiding principles confirming that, among other things, "all human beings are born free and equal in dignity and rights,"[18] that "[e]veryone has the right to the enjoyment of the highest attainable standard of physical and mental health" and governments have the obligation to provide universal access to health care,[19] including family planning and sexual health, and that the "right to development is a universal and inalienable right and an integral part of fundamental human rights."[20]

While the MDGs have, to some extent, neglected the full breadth of reproductive rights,[21] at least three of the eight Goals—the ones addressing maternal health, child health, and

HIV/AIDS—are directly related to sexual and reproductive health. Further, the Goals addressing extreme poverty and gender equality touch on the underlying determinants of health.[22] Additionally, in response to the MDGs' purported neglect of sexual and reproductive health which has "contributed to decreased attention, reduced funding, and increased risks for women and children"[23] two new health-related targets were added to the MDGs to help remedy the deficiencies. Specifically, target 5.B, calling for universal access to reproductive health by 2015, effectively imports the concept of sexual and reproductive health, as conceived under the ICPD, into the MDGs,[24] and affirms the notion that "[t]he Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."[25] Along similar lines, newly incorporated target 6.B, calling for universal access to treatment of HIV/AIDS, bolsters the MDGs' emphasis on health and equality.

III. The Correspondence between the MDGs and Reproductive Rights

There is clear correspondence between the MDGs and reproductive rights, which creates significant entry points for advancing reproductive rights through the MDG agenda. For example, the MDGs promote women's rights generally by calling for greater gender equality, improved maternal health, and reduction of HIV/AIDS and other diseases. Likewise, the recent addition of reproductive health-related targets brings reproductive rights to the fore of the MDG movement. The conceptualization of global development through a human rights lens creates unique opportunities for collaboration between human rights advocates, UN bodies and representatives, international finance agencies, transnational corporations, and civil society to advance human rights.[26]

Human rights advocates should take advantage of the momentum that has grown behind the MDGs and the fact that many of the world's nations are now monitoring their own and each other's progress in realizing the Goals and are, for the most part, taking their commitment to realize those Goals seriously. This reality presents a significant opportunity for reproductive rights advocates to press governments to comply with their human rights obligations as defined under human rights treaties and jurisprudence, as elaborated upon in the Beijing and Cairo consensus documents.

What follows is an analysis of the MDGs and their relevant targets that promote and converge with women's reproductive rights. This discussion, along with the tables outlining the human rights implicated by the pertinent MDGs, can be used by advocates and policy makers as a tool to give content to and inform the implementation of the MDGs.

A. Promote Gender Equality

MDG Goal 1: Eradicate extreme poverty and hunger

Target 1.B: *Achieve full and productive employment and decent work for all, including women and young people.*[27] *(New Target)*

MDG Goal 3: Promote gender equality and empower women

Target 3.A: *Eliminate gender disparity in primary and secondary education preferably by 2005, and in all levels of education no later than 2015.*

The MDGs calling for eradication of poverty and hunger and promotion of gender equality, and their targets touching upon equal access to productive work and education speak directly to the foundation of reproductive rights—that "[a]ll humans beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex."[28]

MDGs 1 and 3 affirm the notion that equality in access to education and employment are indispensable to eradicating poverty and development, a notion that is more fully developed within the human rights framework and essential to the promotion of reproductive rights.

• **MDGs and Targets**

Goal 3 addresses gender equality through the lens of education. It focuses primarily on eliminating gender disparity in primary and secondary education by 2005, and in all levels of education no later than 2015. Elevating women's educational level is fundamental to providing them with knowledge and choices to pursue roles beyond childbearing and overseeing a domestic sphere. According to some experts, the decision to create a target focused specifically on girls' education and equality is "justified by the strong evidence that investing in girls' education yields high returns for girls themselves and high returns for development."[29]

At the 2005 Millennium Review Summit, governments again acknowledged the "critical role" that education plays in poverty eradication and the achievement of other development goals.[30] They affirmed that "progress for women is progress for all" and, reiterating the 2000 MDG target, they resolved to "promote gender equality and eliminate pervasive gender discrimination by . . . eliminating gender inequalities in primary and secondary education by the earliest possible date and at all educational levels by 2015."[31]

Goal 1 and the recent addition of target 1.B after the 2005 World Summit address gender equality through recognition that women have less access to full and productive employment and the impact this has on the proportion of women living in poverty. An estimated one-sixth of the world's population lives in extreme poverty,[32] and women account for 70% of those living in absolute poverty.[33] Many are relegated to the domestic sphere at a young age, a violation of their rights to self-determination and autonomy. In light of these stark statistics, target 1.B directly tackles employment disparities, a major factor perpetuating women's inequality. Nevertheless, as research indicates, while development investment can create jobs for women, "these jobs are often in the export-oriented light industry sector, notorious for low wages, volatility, frequent relocation to areas with cheaper labor, lack of opportunities to learn new skills and lack of upward mobility."[34]

- **Human Rights Framework**

Every major human rights treaty embodies the rights to equality and non-discrimination. Moreover, in-depth analyses and applications of these rights have developed over the years within the UN treaty-monitoring system. For example, article 2 of the Universal Declaration states:

> Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. . . .[35]

Article 1 of CEDAW, the primary human rights treaty protecting and promoting women's equality, provides a detailed definition of discrimination against women:

> [A]ny distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[36]

Moreover, CEDAW calls upon states parties to achieve not only formal but also substantive equality between men and women and provides a detailed list of "appropriate means" to eliminate discrimination against women.[37] Similarly, the Convention on the Rights of the Child (Children's Rights Convention) article 2 prohibits discrimination on several grounds, including sex or other statuses,[38] and the Human Rights Committee (HRC), the body tasked with overseeing implementation of the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant), has interpreted the treaty's equality provisions to require

states parties to eliminate discrimination against women by both public and private actors in all fields, including the provision of services.[39]

Human rights law not only espouses equality, but also addresses the underlying causes of inequality. For example, in addition to requiring governments to refrain from acts of discrimination against women, article 5(a) of CEDAW calls for states parties to:

> Modify social and cultural patterns of conduct of men and women, with the view to achieving the elimination of prejudices and customary and all other practices which are based on the idea or the superiority of either of the sexes or on stereotyped roles for men and women.[40]

Along similar lines, paragraph 7(v) of the Dakar Framework for Action, endorsed by the international community in April 2000, closely mirrors MDG 3 by calling for the elimination of gender disparities in primary and secondary education by 2005, and achievement of gender equality in education by 2015, "with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality."[41]

While the MDGs' focus on discrimination in the areas of employment and education, the human rights framework provides broader conceptions of equality that embrace the full realization of all human rights. For example, the HRC's General Comment 28 (Equality of Rights between Men and Women) recognizes girls' greater vulnerability to discrimination and calls upon states parties to ensure that girls and boys are treated equally in health care, education, and provision of food. The General Comment also specifically asks states parties to eliminate cultural or religious practices that prevent girls from exercising their rights under the Civil and Political Rights Covenant.[42] The Committee on Economic, Social and Cultural Rights also emphasizes, in its General Comment 14 (the Right to the Highest Attainable Standard of Health), that states parties are obliged to prevent any discrimination in the provision of health care services, including in resource allocation.[43]

Human rights jurisprudence also affirms the role that reproductive rights play in realizing the human rights to equality and non-discrimination. Treaty-monitoring bodies have specifically commented upon women's and girls' access to health care and education, among other things, in the context of gender equality. For example, the CEDAW Committee reaffirms, in its General Recommendation 24 (Women and Health), that Convention article 12 ensures women's right to have access to health-care services, information and education on the basis of equality with men. The Committee then asks states parties to pay particular attention to the health education of adolescents, including information on family planning methods.[44] Further, in the Committee's Concluding Observations, it has expressed general concern over women's access to reproductive health services and information and has characterized lack of access as discriminatory against women.[45]

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In sum, calls for increased access to education and employment to achieve greater gender equality and reduce poverty under the MDG framework are, in fact, part of a larger, overarching human rights framework. Moreover, the MDGs promoting gender equality are, to some extent, given an explicit normative framework and greater political force when they are informed by the human rights framework and its related jurisprudence.[46] As "[t]he twin principles of non-discrimination and equality are among the most fundamental elements of international human rights," the international human rights system can provide a wealth of experience on non-discrimination and equality to MDG initiatives.[47] On the other hand, the MDGs are one means to gauge progress regarding governments' compliance with the overarching obligation to achieve gender equality in all the spheres of the public and private life.

Table 1: International Human Rights Promoting Gender Equality

Human Rights Protected	International Instruments (Treaties and Conference Documents)
The right to non-discrimination	• *Universal Declaration of Human Rights, art. 2* • *International Covenant on Economic, Social and Cultural Rights, art. 3* • *International Covenant on Civil and Political Rights, arts. 2, 24* • *Convention on the Elimination of All Forms of Discrimination Against Women, all articles* • *Convention on the Rights of the Child, art. 2* • *Programme of Action of the International Conference on Population and Development (Cairo), Principles 1 and 4* • *Fourth World Conference on Women (Beijing), para. 214*
The right to education	• *Universal Declaration of Human Rights, art. 26* • *International Covenant on Economic, Social and Cultural Rights, art. 13* • *Convention on the Elimination of All Forms of Discrimination against Women, art. 10* • *Convention on the Rights of the Child, art. 28* • *Fourth World Conference on Women (Beijing), para. 71*
The right to equal protection	• *International Covenant on Civil and Political Rights, art. 26*
The right to work	• *Universal Declaration of Human Rights, art. 23* • *International Covenant on Economic, Social and Cultural Rights, art. 6* • *Convention on the Elimination of All Forms of Discrimination against Women, art. 11* • *Programme of Action of the International Conference on Population and Development (Cairo), para. 3.18*

B. Improve Maternal Health

MDG Goal 5: Improve Maternal Health

Target 5.A: *Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.*

Target 5.B: *Achieve, by 2015, universal access to reproductive health.* **(New Target)**

MDG Goal 8: Develop a global partnership for development

Target 8.E: *In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.*

Target 8.F: *In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.*[48]

One striking feature of the MDGs is the prominence of the right to health within the eight Goals.[49] As asserted by the Secretary-General, "[g]ood health is not just an outcome of poverty reduction and development: it is a way of achieving them[,]" as well as a large component of international human rights obligations.[50] With respect to MDG 5's focus on women's maternal health, which falls squarely within the human right to health, the Goal touches directly upon governments' obligations under both CEDAW and the ICPD Programme of Action to ensure universal access to reproductive health services. Along similar lines, MDG 8 and the targets focusing on access to essential drugs and new technology speak directly to important aspects of women's reproductive rights, including access to modern contraception, safe abortion services, and advanced medical care, including emergency obstetric care.

• MDGs and Targets

While maternal health is not specifically referenced in the Millennium Declaration, MDG 5 explicitly focuses on maternal health and target 5.A closely mirrors the ICPD Programme of Action by calling for a reduction in maternal mortality by three-quarters by 2015.[51] The focus of MDG 5 on maternal mortality is premised upon the harsh reality that maternal death accounts for the greatest proportion of deaths among women of reproductive age,[52] the majority of which are preventable,[53] thus amounting to a significant global health emergency.[54] In fact, in 2005 the estimated number of maternal deaths worldwide was 536,000.[55] In contrast, there is no single cause of death and disability for men between the ages of 15 and 44 that approaches the magnitude of maternal death and disability.[56]

Discussions surrounding maternal health expanded during the 2005 Millennium Summit, where governments resolved to "ensur[e] equal access to reproductive health."[57] They went on to add target 5.B, calling for governments to "[a]chieve, by 2015, universal access to reproductive health."[58] In doing so, governments essentially incorporated the ICPD Programme of Action and Beijing Platform for Action into MDG 5."[59]

Goal 8 calling for a global partnership for development, and targets 8.E and 8.F calling for access to essential drugs in developing countries and to the benefits of new technologies similarly implicate women's reproductive rights and health, specifically as they relate to maternal health. Targets 8.E and 8.F are central to women's reproductive rights because they highlight the need for equity among those of all income levels in accessing essential drugs and the benefits of new technologies. Essential drugs are those that "satisfy the priority health care needs of a population" and are selected with "due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness."[60] Essential drugs for reproductive health include contraceptives, drugs for the prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS, and drugs to ensure healthy pregnancy and delivery.[61]

The ability to access all available methods to control one's fertility and drugs and medical technology to ensure safe childbirth has eluded large numbers of low-income women. Similarly, access to affordable, life-saving drugs for all women living with HIV/AIDS—regardless of whether they are pregnant or likely to become pregnant—is far from reality in most low-income settings.

Access to new technology has the potential to greatly enhance people's lives, especially those of women in developing countries. Women stand to benefit immensely from new technologies that make their lives easier and improve their health, such as vaccines and new reproductive health drugs and treatments.[62] Unfortunately, at present, access to and resources for development of such technology in developing countries is limited. As the UN Millennium Project's Task Force on Science, Technology and Innovation noted, "the scientific, engineering and technology community has yet to be development motivated."[63]

- **Human Rights Framework**

MDGs 5 and 8 are well-supported by fundamental human rights. Promoting women's maternal health calls upon a number of these rights, including the rights to life, health, equality and non-discrimination, autonomy, and to benefit from scientific progress. The fulfillment of these rights is instrumental in guaranteeing women's right to survival before, during, and after birth.

Needless deaths due to complications relating to pregnancy and childbirth can deprive women of their right to life as protected by international human rights instruments.[64] Under the Civil and Political Rights Covenant, "[e]very human being has the inherent right to life[,]" and no one shall be arbitrarily deprived of his or her life.[65] With respect to government obligations, states parties are obliged not only to refrain from arbitrary killings, but to take affirmative measures to protect people from arbitrary and preventable losses of life.[66] This includes measures to prevent unnecessary and avoidable losses of life related to pregnancy and childbirth or its mismanagement,[67] to ensure that health services are accessible, and to ensure that women are not "forced to undergo clandestine abortions, which endanger their lives."[68] Treaty-monitoring bodies such as the HRC and the CEDAW Committee have also repeatedly expressed concern over high rates of maternal mortality,[69] and have explicitly recognized maternal mortality as a violation of women's right to life.[70]

The right to the highest attainable standard of health is a major component of maternal health. The Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant) establishes that "[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[71] This right entails "the right to control one's health and body, including sexual and reproductive freedom."[72] Similarly, article 12 of CEDAW states that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[73] Article 12 further calls upon states parties to provide women "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[74]

In addition to treaty protections of the right to health, the "Key Actions" to the five-year review of the ICPD, a set of renewed government commitments, calls for "[e]nsur[ing] that reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care, well-equipped and adequately staffed maternal health care services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, postpartum care and family planning."[75]

With respect to governments' obligations, General Recommendation 24 (Women and Health) of the CEDAW Committee calls upon states parties to "ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services."[76] Similarly, General Comment 14 (Right to Health) of the Committee on Economic, Social and Cultural Rights Covenant confirms that states parties

must provide "a full range of high quality and affordable health care, including sexual and reproductive services."[77] In addition to being physically accessible and affordable, services must be widely available, provided in a manner acceptable to women, and of high quality.[78] In the context of maternal health care, this involves ensuring that all pregnant women have access to pre- and post-natal care, trained birth attendants, emergency obstetric care, and family planning services and information.[79] Along similar lines, states parties are also obligated to remove barriers that deny women access to reproductive and sexual health services, information, and education.[80]

While aspects of the right to health are subject to progressive realization and resource constraints, according to the former UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, Paul Hunt, there are certain immediate obligations such as the duty of a state to "respect an individual's freedom to control his or her body."[81] States also have an obligation to "ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary."[82] On a related note, the Committee on Economic, Social and Cultural Rights confirms in its General Comment 14 (Right to Health) that "[d]epending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required . . . ."[83]

Issues of maternal health also involve the fundamental right to equality and non-discrimination. In fact, the grave statistics regarding maternal mortality and morbidity around the world confirm the severity of "systematic inequality and discrimination suffered by women throughout their life cycle, perpetuated by formal laws, policies and prejudicial social norms and practices harmful to women."[84] They also highlight the larger issue of discrimination against certain groups of women on the basis of age, race, ethnicity, and health status, among other conditions. As discussed in section III.A of this briefing paper, governments have affirmative obligations to prevent discrimination in the realms of education, food provision, and access to health care, including resource allocation. With respect to women's reproductive health, CEDAW obligates states to take immediate steps to eliminate discrimination against women in the field of health care, particularly with respect to family planning,[85] and explicitly asserts that "the role of women in procreation should not be a basis for discrimination."[86] The CEDAW Committee has also noted in its General Recommendation 24 (Women and Health) that restrictions on health services needed only by women may constitute discrimination.[87]

Finally, women's maternal health hinges on the human rights to reproductive autonomy and to access the benefits of scientific progress. With regard to reproductive autonomy,

women have the right to make informed decisions about their reproductive lives. This right is implicit in the rights to physical integrity, liberty, privacy, and family life, and is explicitly articulated in the ICPD Programme of Action, Beijing Platform for Action, and CEDAW. Moreover, CEDAW obliges states parties to ensure that men and women share equally "[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[88] Therefore, states parties are obliged to ensure women's access to a full range of family planning services and contraceptive choices, as well as to a wide range of reproductive health services, including safe abortion.[89] These obligations are directly in line with MDG 5's new target calling for "universal access to reproductive health."[90]

Realizing women's right to reproductive autonomy also requires access to the benefits of scientific progress. The Universal Declaration and the Covenant on Economic, Social and Cultural Rights explicitly guarantee "the right to enjoy the benefits of scientific progress and its applications."[91] Further, the Beijing Platform for Action notes that governments are responsible for "financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable methods for the regulation of fertility, including natural family planning for both sexes . . . ."[92] Fortunately, maternal mortality and morbidity are becoming increasingly preventable due to significant strides in medical science and technology. Women can avoid pregnancy-related death through the use of modern contraceptives, access to safe abortion services for unwanted pregnancies, and timely diagnosis of complications and interventions such as emergency obstetric care. However, access to these technological advancements is inequitable, with women living in developing countries at greatest risk.

In sum, there is notable correspondence between the MDG agenda and the human rights framework with regard to women's reproductive rights and health. In fact, MDGs 5 and 8 and their pertinent targets 5.A (reduce maternal mortality ratio by three-quarters), 5.B (universal access to reproductive health), 8.E (access to essential drugs for developing countries), and 8.F (access to new technologies) are built largely upon human rights obligations and thus support advocacy to advance women's reproductive rights. In particular, the MDGs provide a means of monitoring compliance with human rights obligations in the area of reproductive rights. At the same time, incorporating a human rights approach to the health related goals, is critical to enhancing the possibilities of achieving them. As the UN Secretary-General has asserted "greater recognition of the right to health will reduce [the] technocratic tendencies [of the MDG agenda], enhance participation of disadvantaged individuals and communities, and thereby improve the

chances of achieving the health-related Millennium Development Goals for all."[93] As governments take steps to meet their maternal health MDG commitments, depending on the steps taken, they may be simultaneously taking steps to comply with their longstanding human rights commitments.

Table 2: International Human Rights Protecting and Promoting Maternal Health

Human Rights Protected	International Instruments (Treaties and Conference Documents)
The right to life	• *Universal Declaration of Human Rights, art. 3* • *International Covenant on Civil and Political Rights, art. 6.1* • *Convention on the Rights of the Child, art. 6* • *Programme of Action of the International Conference on Population and Development (Cairo), Principle 1*
The right to health, reproductive health, and family planning	• *Universal Declaration of Human Rights, art. 25* • *International Covenant on Economic, Social and Cultural Rights, art. 12* • *Convention on the Elimination of All Forms of Discrimination Against Women, arts. 10(h), 12, 16(e)* • *Convention on the Rights of the Child, art. 24* • *International Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv)* • *Programme of Action of the International Conference on Population and Development (Cairo), Principle 8, paras. 7.2, 7.3* • *Fourth World Conference on Women (Beijing), paras. 89, 94*
The right to privacy	• *International Covenant on Civil and Political Rights, art. 17*
The right to special protection for mothers	• *International Covenant on Economic, Social and Cultural Rights, art. 10(2)*
The right to determine the number and spacing of one's children	• *Convention on the Elimination of All Forms of Discrimination against Women, art. 16(e)* • *Programme of Action of the International Conference on Population and Development (Cairo), Principle 8, para. 7.3* • *Fourth World Conference on Women (Beijing), paras. 95, 223*
The right to benefit from scientific progress and/or technology	• *International Covenant on Economic, Social and Cultural Rights, art. 15(1)(b)* • *Convention on the Elimination of All Forms of Discrimination against Women, art. 14(2)(g)*

C. Combat HIV/AIDS

MDG Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 6.A: *Have halted by 2015 and begun to reverse the spread of HIV/AIDS.*

Target 6.B: *Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.* **(New Target)**

MDG Goal 8: Develop a global partnership for development

Target 8.E: *In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.*

Target 8.F: *In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.*

Gender inequality has been widely accepted as a principal factor fueling the HIV/AIDS pandemic. In addition to increased physiological susceptibility, deeply-rooted and widespread practices such as cultural norms of sexual ignorance, economic dependence and gender-based violence contribute to making women especially vulnerable to HIV/AIDS.[94] These practices must be addressed in order to halt and reverse the spread of HIV/AIDS.

• MDGs and Targets

Goal 6, to combat HIV/AIDS, malaria and other diseases, stems from the international community's recognition that certain diseases—both old and new—are a severe impediment to development and people's enjoyment of their human rights. HIV/AIDS was first brought to the world's attention a quarter of a century ago and since then has killed more than 25 million people.[95] Today it surpasses both malaria and tuberculosis in number of lives lost each year. In 2005 alone, AIDS claimed close to three million lives and over four million more became infected with HIV.[96]

During the Millennium Summit, governments resolved to halt and begin reversing the spread of HIV/AIDS, malaria, and other major diseases by 2015. These commitments were reflected in the MDGs with the target for Goal 6: to halt by 2015 and begin to reverse the spread of HIV/AIDS. Recognizing the vast, global nature of the HIV/AIDS epidemic, the MDG agenda also calls for the establishment of greater global partnerships for development under MDG 8, particularly with regard to providing access to essential drugs in developing countries and to new technologies under targets 8.E and 8.F.

Governments reinforced the need to prioritize Goal 6 at the 2005 Millennium Review Summit, when they recognized the severity of the pandemic and the challenges that it posed to the achievement of other MDGs. In doing so, they added target 6.B, which calls for universal access to HIV/AIDS treatment for all those who need it, by 2010. Governments thereby committed themselves to a wide-range of measures to address HIV/AIDS, including improving health systems, mobilizing resources, developing programs aimed at universal access to treatment of HIV/AIDS, and meeting the ICPD goal of universal access to reproductive health care.[97]

• **Human Rights Framework**

The HIV/AIDS pandemic has been fueled, in many ways, by widespread human rights violations. "Where individuals and communities are able to realize their rights—to education, free association, information and, most importantly, non-discrimination—the personal and societal impact of HIV and AIDS are reduced."[98] In that regard, it is essential to approach the HIV/AIDS pandemic through the lens of human rights, in order to mitigate the spread of the disease as well as its social and economic impact.[99]

The protection and fulfillment of the right to health are critical to addressing the HIV/AIDS pandemic. As noted in section III B., the right to health requires that every person have access to quality health care. Similar to the calls of MDGs 6 and 8, international standards require governments to ensures access to HIV/AIDS treatment and care, including education about HIV/AIDS,[100] voluntary and confidential counseling and testing, and access to needed medications for people of all socio-economic statuses. Governments are also obligated to prevent discrimination against people living with HIV/AIDS and to take measures to prevent the spread of HIV/AIDS.[101]

The Committee on Economic, Social and Cultural Rights has specifically recommended legislative[102] and social measures[103] to combat the spread of HIV/AIDS, including through international cooperation (i.e., with the World Health Organization and UNAIDS).[104] The Committee has also called upon states parties to improve health services[105] and to address the high cost of medicines in response to the HIV/AIDS pandemic.[106] Moreover, the CEDAW Committee has called upon states parties to conduct awareness-raising and education programs,[107] reproductive and sexual health education programs,[108] and promotion of condom use.[109] Along similar lines, the HRC has called upon states parties to make general efforts to prevent and combat HIV/AIDS and other communicable diseases,[110] and has advocated for education and prevention programs for adolescents.[111]

Over the years, the HIV/AIDS pandemic has become an increasingly gendered phenomena.[112] In some Caribbean countries, girls aged 15-to-19 are up to five times more likely than boys in their age group to be HIV-positive.[113] In sub-Saharan Africa (part of a continent being ravaged by HIV/AIDS), women are at least 1.3 times more likely to be infected by HIV than men, and among those 15–24 years, women are three times more likely to be infected as men.[114] In the United States, teen girls have represented 43% of AIDS cases reported among 13-19 year olds in recent years.[115] Women's vulnerability to HIV/AIDS is primarily due to widespread gender inequality.[116] This vulnerability is compounded by other human rights violations such as "inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affect the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce."[117] In response to these realities, the CEDAW Committee, in its General Recommendation 24 (Women and Health), asks states parties to address the needs of HIV-positive women, as well as prevent discrimination against them.[118] Along similar lines, the HRC has asked states parties to integrate a gender perspective in all health-related policies, planning, programs, and research.[119]

In addition to addressing the gendered dimensions of HIV/AIDS generally, governments must specifically protect the human rights of pregnant women living with HIV/AIDS. Pregnant women with HIV/AIDS often suffer privacy rights violations, infringements on individual and reproductive autonomy rights, and stark discrimination. Therefore, governments have an obligation to ensure informed consent to HIV testing and treatment, protect confidentiality in the provision of HIV-related health care, and take measures to prevent discrimination within health-care settings against people living with or thought to be living with HIV/AIDs.

Women at risk of or living with HIV/AIDS need protection of their human rights to health, equality and non-discrimination, reproductive autonomy, and information and education. Governments must provide access to life-saving treatment and care, but also address cultural norms that "dictate a passive role for women in sexual interactions and strong social pressures for women and girls to remain ignorant about sexual matters . . . ."[120]

The emphasis of the MDGs on both stemming the HIV pandemic, and addressing gender inequality, provides a unique opportunity to make headway in improving governments' compliance with human rights obligations, particularly in the area of women's reproductive rights.

Table 3: International Human Rights Requiring States to Combat HIV/AIDS

Human Rights Protected	International Instruments (Treaties and Conference Documents)
The right to life	• *Universal Declaration of Human Rights, art. 3* • *International Covenant on Civil and Political Rights, art. 6.1* • *Convention on the Rights of the Child, art. 6* • *Programme of Action of the International Conference on Population and Development (Cairo), Principle 1*
The right to health	• *Universal Declaration of Human Rights, art. 25* • *International Covenant on Economic, Social and Cultural Rights, art. 12* • *Convention on the Elimination of All Forms of Discrimination Against Women, art. 12* • *Convention on the Rights of the Child, art. 24* • *International Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv)* • *Programme of Action of the International Conference on Population and Development (Cairo), Principle 8* • *Fourth World Conference on Women (Beijing), para. 89*
The right to privacy	• *International Covenant on Civil and Political Rights, art. 17*
The right to benefit from scientific progress and/or technology	• *International Covenant on Economic, Social and Cultural Rights, art. 15(1)(b)* • *Convention on the Elimination of All Forms of Discrimination against Women, art. 14(2)(g)*

Endnotes

1. *United Nations Millennium Project*, 2006, *available at* http://www.unmillenniumproject.org/goals/index.htm.
2. Road Map Towards the Implementation of the United Nations Millennium Development Declaration: Report of the Secretary-General, U.N. Doc. A/56/326 (2001), [hereinafter Millennium Declaration – Road Map], *available at* http://www.un.org/documents/ga/docs/56/a56326.pdf.
3. *See* United Nations Report of the Secretary-General on the Work of the Organization, U.N. Doc. A/62/1 (2007), *available at* http://www.un.org/documents/ga/docs/56/a561.pdf.
4. Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Note by the Secretary-General, at 4, U.N. Doc No. A/59/422 (2004) [hereinafter Right to Health – 2004 Note by Secretary-General], *available at* http://files.institut-fuer-menschenrechte.de/576/childSurvival.pdf. (Addressing what the right to health and applications of the human rights framework brings to the MDGs).
5. *See* Christina T. Holder, *Note: A Feminist Human Rights Law Approach for Engendering the Millennium Development Goals*, 14 Cardozo J. L. & Gender 125, 144 (2007), [hereinafter *Feminist Human Rights Approach – Engendering the MDGs*].
6. *See Id.* at 127.
7. *See* Right to Health – 2004 Note by Secretary-General, *supra* note 4, at para. 30
8. *See Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
9. *See Beijing Declaration and the Platform for Action,* Fourth World Conference on Women, Beijing, China, Sept. 4-15, 1995, U.N. Doc. A/CONF.177/20 (1995) [hereinafter *Beijing Declaration and Platform for Action*].
10. Center for Human Rights and Global Justice, Human Rights Perspectives on the Millennium Development Goals 17 (2003), *available at* http://www.chrgj.org/images/NYUCHRGJMDGREPORT2003.pdf.
11. Millennium Declaration- Road Map, *supra* note 2, at para. 202.
12. *Feminist Human Rights Approach – Engendering the MDGs*, *supra* note 5, at 143–144 (citing Millennium Declaration - Road Map, *supra* note 2).
13. *Feminist Human Rights Approach – Engendering the MDGs, supra* note 5, at 127 (citing Millennium Declaration, *supra* note 2, at 25).
14. *See* United Nations Millennium Declaration, *adopted* Sept. 8, 2000, G.A. Res. 55/2, U.N. GAOR, 55th Sess., U.N. Doc. A/55/2 (2000), [hereinafter Millennium Declaration], *available at* http://www2.ohchr.org/english/law/millennium.htm.
15. The Right of Everyone to the Enjoyment of the Highest Standard of Physical and Mental Health - Report of the Special Rapporteur, Paul Hunt, para 7, U.N. Doc. E/CN.4/2004/49 (2004), [hereinafter Right to Health – Report of the Special Rapporteur], *available at* http://www.unhchr.ch/Huridocda/Huridoca.nsf/e06a5300f90fa0238025668700518ca4/8585ee19e6cf8b99c1256e5a003524d7/$FILE/G0410933.pdf.
16. *ICPD Programme of Action*, *supra* note 8, at para. 7.2.
17. *Id.* at para. 7.3.
18. *Id.* at prin. 1.
19. *Id.* at prin. 8.
20. *Id.* at prin. 3. The former Special Rapporteur on Health, Paul Hunt, confirmed that the ICPD

principles "provide a human rights framework upon which to construct sexual and reproductive health law, policies, programmes and projects." Right to Health – Report of the Special Rapporteur, *supra* note 12, at para. 17.

21. *See generally* Arlett C. White, Thomas W. Merrick, and Abdo S. Yazbeck, *Reproductive Health: The Missing Millennium Development Goal: Poverty, Health and Development in the Changing World*, THE WORLD BANK (2006).
22. *See* Right to Health – Report of the Special Rapporteur, *supra* note 15, at para. 8.
23. COUNTDOWN TO 2015, MATERNAL, NEWBORN & CHILD SURVIVAL, TRACKING PROGRESS IN MATERNAL, NEWBORN & CHILD SURVIVAL (2008), *available at* http://www.countdown2015mnch.org/reports.
24. *See* Stan Bernstein, Lale Say and Sadia Chowdhury, *Sexual and Reproductive Health: Completing the Continuum*, THE LANCET, Vol. 371, No. 9620, 1225 (2008).
25. UNFPA, MASTER PLAN FOR DEVELOPMENT: HOW THE ICPD PROGRAMME OF ACTION SUPPORTS THE MDGS, *available at* http://www.unfpa/org/icpd/mdgs-icpd.cfm.
26. *See Feminist Human Rights Approach – Engendering the MDGs, supra* note 5, at 144.
27. An additional target for MDG 1 calls for reducing by half the proportion of people living on less than a dollar a day and the proportion of people who suffer from hunger.
28. Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at preamble, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981), [hereinafter CEDAW]; *see also ICPD Programme of Action*, *supra* note 8, at prin. 1.
29. MILLENNIUM PROJECT, TAKING ACTION: ACHIEVING GENDER EQUALITY AND EMPOWERING WOMEN 28 (2005), *available at* http://www.unmillenniumproject.org/documents/Gender-complete.pdf (citing T. Paul Schultz, *Returns to Women's Schooling, in* WOMEN'S EDUCATION IN DEVELOPING COUNTRIES: BARRIERS, BENEFITS, AND POLICY (Elizabeth King & M. Anne Hill eds., 1993)).
30. 2005 World Summit Outcome, *adopted* Sept. 14-16, 2005, G.A. Res. 60/1, U.N. GAOR, 60th Sess., at para. 43, U.N. Doc. A/60/1 (2005), [hereinafter World Summit Outcome], *available at* http://www.unep.org/greenroom/documents/outcome.pdf.
31. *Id.* at para. 58-58(a).
32. *See* MILLENNIUM PROJECT, ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS, *available at* http://www.unmillenniumproject.org/who/index.htm. The World Bank defines extreme poverty as living on less than one dollar per day.
33. *See* Report of the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, Mr. Miloon Kothari, submitted pursuant to Commission resolution 2000/9, para. 4,U.N. Doc. E/CN.4/2001/51 (2001), *available at* http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/e1da15286e4a955fc12569f40033accc/$FILE/G0110587.pdf.
34. *Feminist Human Rights Approach – Engendering the MDGs*, *supra* note 5, at 146–147.
35. Universal Declaration of Human Rights, *adopted* Dec.10, 1948, G.A. Res. 217A (III), U.N. Doc. A/810 at 71(1948), [hereinafter Universal Declaration], *available at* http://www.un.org/Overview/rights.htm.
36. CEDAW, *supra* note 28, at art. 1.
37. *Id.* at art. 2. CEDAW article 2 calls upon states parties to: "(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle; (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women; (c) To establish legal

protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination; (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation; (e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise; (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; (g) To repeal all national penal provisions which constitute discrimination against women."

38 *See* Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, art. 2, U.N. Doc. A/44/49 (1989) (entry into force Sept. 2, 1990), *available at* http://www.unhchr.ch/html/menu3/b/k2crc.htm.

39. *See* Human Rights Committee, *General Comment 28*: Equality of Rights Between Men and Women (Art.3) (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 168, para. 31, U.N. Doc. HRI/GEN /1/Rev.5 (2001), [hereinafter Human Rights Committee, *General Comment 28*)].

40. CEDAW, *supra* note 28, at art. 5(a).

41. Dakar Framework for Action, Education for All: Meeting our Collective Commitments, *adopted* by the World Education Forum, Dakar, Senegal, Apr. 26-28, 2000, at 9, para. 7(v) (Paris, UNESCO, 2000). *See* Human Rights Committee, *General Comment 28*, *supra* note 39, at 168, para. 28.

42. *See Id.*

43. *See* Committee on Economic, Social and Cultural Rights, *General Comment 14:* The Right to the Highest Attainable Standard of Health (Art. 12) (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, para. 19, U.N. Doc. HRI/GEN/1/Rev.5 (2001), [hereinafter CESCR, *General Comment 14*].

44. *See* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation 24: Women and Health,* at paras. 23, 244, U.N. Doc. A/54/38 (1999), [hereinafter CEDAW Committee, *General Recommendations 24*], *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/77bae3190a903f8d80256785005599ff?Opendocument.

45. *See* CEDAW Committee, *Concluding Observations:* Bangladesh, para. 438, U.N. Doc. A/52/38/Rev.1, Part II (1997); CEDAW Committee, *Concluding Observations:* Ethiopia, para. 160, U.N. Doc. A/51/38 (1996); CEDAW Committee, *Concluding Observations:* Iraq, para. 203, 204, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations:* Lithuania, paras. 158, 159,U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations:* Mongolia, para. 267, U.N. Doc . A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Nicaragua, paras. 300, 301, 303, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Peru, para. 341, U.N. Doc. A/53/38/Re v.1, para. 337 (1998); CEDAW Committee, *Concluding Observations:* Vietnam, para. 266, U.N. Doc. A/56/38 (2001).

46. *See* Right to Health – Report of the Special Rapporteur, *supra* note 15, at para. 48.

47. Right to Health – Note by the Secretary-General, *supra* note 4, at para. 21.

48. Additional MDG 8 targets include developing further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction — both nationally and internationally); addressing the special needs of the least developed countries (includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPCs and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction);

addressing the special needs of landlocked countries and small island developing States; dealing comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term; and in cooperation with developing countries, developing and implementing strategies for decent and productive work for youth.

49. *See* Right to Health – 2004 Note by Secretary-General, *supra* note 4, at para. 11.
50. *Id.* at para. 13.
51. *See* Millennium Declaration, *supra* note 14, at para. 19; *ICPD Programme of Action*, *supra* note 8, at para 8.21.
52. *See* UNFPA, State of the World Population: The Cairo Consensus Documents at Ten: Population, Reproductive Health and the Global Effort to End Poverty 76 (2004), *available at* http://www.unfpa.org/swp/2004/pdf/en_swp04.pdf. Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." *See also*, WHO, Maternal Mortality in 2005 4 (2007), *available at* http://www.who.int/reproductivehealth/publications/maternal_mortality_2005/mme_2005.pdf.
53. *See* Center for Reproductive Rights, Claiming Our Rights: Surviving Pregnancy and Childbirth in Mali 4 (2003), [hereinafter Surviving Pregnancy and Childbirth], *available at* http://www.reproductiverights.org/pdf/pub_bp_surviving_0105.pdf.
54. See Paul Hunt, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Statement to the General Assembly, Third Committee, Oct. 19, 2006, *available at* http://www.ifhhro.org/UserFiles/Paul_Hunt_GA_2006.pdf ("It is time to recognize that avoidable maternal mortality is a human rights problem on a massive scale.").
55. *See* WHO, UNICEF, UNFPA, The World Bank, Maternal Mortality in 2005 8 (2005), *available at* http://www.who.int/whosis/mme_2005.pdf; *see also* UN Millennium Project, UNDP, Stan Bernstein with Charlotte Juul Hansen, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* 3, 42 (2006), *available at* http://www.unfpa.org/publications/docs/sexual_health.pdf.
56. *See* Human Rights Centre – University of Essex, UNFPA, Reducing Maternal Mortality – The Contribution of the right to the highest attainable standard of Health 4 *available at* http://www2.essex.ac.uk/human_rights_centre/rth/docs/ReducingMaternalMortality.pdf.
57. World Summit Outcome, *supra* note 30, at para. 58(c).
58. *Id.* at para. 57(g).
59. *Id.*
60. WHO, Essential Medicines, *available at* http://www.who.int/medicines/services/essmedicines_def/en/index.html.
61. *See* WHO ET. AL., The Interagency List of Essential Medicines for Reproductive Health 1 (2006), *available at* http://www.who.int/medicines/publications/essentialmedicines/WHO-PSM-PAR-2006%20I_Rev.pdf. The WHO, in collaboration with other major international and nongovernmental organizations who work in the field of reproductive health, published an Interagency List of Essential Medicines for Reproductive Health in 2006. This list was developed after a study confirmed notable discrepancies between the existing essential medicines lists of the various UN agencies, (including the 2002 draft UNFPA/WHO list, the Interagency UNFPA/UNAIDS/WHO Reproductive Health Medicines and Commodities List, and the 13th

WHO Model List of Essential Medicines of 2003), and subsequent consultations to realign the selection of essential medicines for reproductive health. "The basic objective [of the updated Interagency List] has been to ensure that all reproductive health medicines on the interagency list are also part of the WHO Model List of Essential Medicines."

62. *See* UN Millennium Project, Background Paper of the Task Force on Science, Technology and Innovation 8 (2003), *available at* http://www.unmillenniumproject.org/documents/tf10apr18.pdf.
63. *Id.*
64. *See* Surviving Pregnancy and Childbirth, *supra* note 53, at 65.
65. International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, art. 6 (1), U.N. Doc A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976), *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm.
66. *See* Human Rights Committee, *General Comment 06*: *The Right to Life*, para. 3, art.6 (1982), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument.
67. *See* Human Rights Committee, *General Comment 28*, *supra* note 39, at para. 10.
68. Human Rights Committee, *Concluding Observations:* Mali, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).
69. *See* Human Rights Committee, *General Comment 28, supra* note 39, at para. 10; s*ee also* CEDAW Committee*, Concluding Observations:* Argentina, para. 360, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations:* Argentina, para. 380, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations:* Bosnia and Herzegovina, para. 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); CEDAW Committee, *Concluding Observations:* Brazil, para. 126, U.N. Doc. A/58/38 (2003); CEDAW Committee, *Concluding Observations:* Burkina Faso, para. 349, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations:* Cambodia, para. 29, U.N. Doc. CEDAW/C/KHM/CO/3 (2006); CEDAW Committee, *Concluding Observations:* Cameroon, para. 59, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations:* Eritrea, para. 62, U.N. Doc. CEDAW/C/ERI/CO/3 U.N. Doc. A/57/38, Part I (2006); CEDAW Committee, *Concluding Observations:* Gambia, para. 203, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations:* Georgia, para. 111, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* Ghana, para. 31, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); CEDAW Committee, *Concluding Observations:* Guatemala, para. 192, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations:* India, para. 78, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations:* India, para. 40, U.N. Doc. CEDAW/C/IND/CO/3 (2007); CEDAW Committee, *Concluding Observations:* Laos People's Democratic Republic, para. 96, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations:* Mexico, para. 32, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); CEDAW Committee, *Concluding Observations:* Peru, para. 482, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations*: Philippines, para. 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006); CEDAW Committee, *Concluding Observations:* Tajikistan, para. 31, U.N. Doc. CEDAW/C/TJK/CO/3 (2007); CEDAW Committee, *Concluding Observations:* Ukraine, para. 289, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations:* United Republic of Tanzania, para. 237, U.N. Doc. A/53/38/Rev.1 (1998); CEDAW Committee, *Concluding Observations:* Yemen, para. 397, U.N. Doc. A/57/38 (2002).
70. *See* CEDAW Committee, *Concluding Observations:* Belize, para. 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* Colombia, para. 393, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* Dominican Republic, para. 337, U.N. Doc. A/53/38

(1998); CEDAW Committee, *Concluding Observations:* Madagascar, para. 244, U.N. Doc. A/49/38 (1994); *see also,* Human Rights Committee, *Concluding Observations*: Bolivia, para. 22, U.N. Doc. CCPR/C/79/Add.74 (1997); Human Rights Committee, *Concluding Observations:* Guatemala, para. 19, U.N. Doc. CCPR/CO/72/GTM; Human Rights Committee, *Concluding Observations:* Hungary, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002); Human Rights Committee, *Concluding Observations:* Libyan Arab Jamahiriya, para. 9, U.N. Doc. CCPR/C/79/Add.101 (1998); Human Rights Committee, *Concluding Observations:* Mongolia, para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); Human Rights Committee, *Concluding Observations:* Paraguay, para. 123, U.N. Doc. A/51/38 (1996); Human Rights Committee, *Concluding Observations:* Senegal, para. 12, U.N. Doc. CCPR/C/79/Add 82 (1997); Human Rights Committee, *Concluding Observations:* Sudan, para. 10, U.N. Doc. CRC/C/15/Add.10 (1993); Human Rights Committee, *Concluding Observations:* Zambia, para. 9, U.N. Doc. CCPR/C/79/Add.62 (1996).

71. CESCR, *General Comment 14*, *supra* note 43, at para. 1.
72. *Id.* at para. 8.
73. CEDAW, *supra* note 28, at art. 12.
74. *Id.* at art. 12.
75. Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, June 30-July 2, 1999, para. 62(b), U.N. GAOR, 21st Special Sess., U.N. Doc. A/S-21/5/Add.1 (1999).
76. CEDAW Committee, *General Recommendation 24*, *supra* note 44, at para. 29.
77. CESCR, *General Comment 14*, *supra* note 43, at para. 21.
78. *See Id.* at para. 21.
79. *See Id.* at para. 14.
80. *See Id.* at para 34.
81. Right to Health – Report of the Special Rapporteur, *supra* note 15, at para. 27.
82. *Id.* at para. 29.
83. CESCR, *General Comment 14*, *supra* note 43, at para. 49.
84. Surviving Pregnancy and Childbirth, *supra* note 53, at 7.
85. *See* CEDAW, *supra* note 28, at art. 12 (1).
86. *Id.* at preamble.
87. *See* CEDAW Committee, *General Recommendation 24*, *supra* note 44, at para. 2.
88. CEDAW, *supra* note 28, at art. 16.1(e).
89. *See* Surviving Pregnancy and Childbirth, *supra* note 53, at 8.
90. ECOSOC, United Nations Statistic Division, Millennium Development Goal Indicators (2008), *available at* http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm.
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100. *See e.g.*, CEDAW Committee, *Concluding Observations:* Burundi, para. 60, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Colombia, para 346, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* Guyana, para. 179, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Iraq, para. 203, U.N. Doc . A/55/38 (2000); CEDAW Committee, *Concluding Observations:* Myanmar, para. 96 U.N. Doc . A/55/38 (2000); CEDAW Committee, *Concluding Observations:* Vietnam, para. 267, U.N. Doc. A/56/38 (2001).
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109. *See, e.g.*, CEDAW Committee, *Concluding Observations:* Belize, para. 59, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* Burundi, para. 60, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Guinea, para.131, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations:* Uganda, para. 313, U.N. Doc. A/50/38 (1995); CEDAW Committee, *Concluding Observations:* Vietnam, para. 267, U.N. Doc. A/56/38 (2001).
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