CENTER FOR REPRODUCTIVE RIGHTS

Submission to the United Nations Office of the High Commissioner for Human Rights for the preparation of the thematic study on Maternal Mortality, Morbidity and Human Rights

This submission responds to the OHCHR Note Verbale's request for information for the preparation of the upcoming OHCHR thematic study on preventable maternal mortality and morbidity and human rights. It first presents the human rights legal framework on maternal mortality and morbidity,[1] under which states have a legal obligation to ensure women's safety throughout pregnancy and childbirth. It then describes a sample of the key issues that contribute to high rates of maternal mortality and morbidity and which constitute violations of government's international human rights obligations. Finally, it briefly discusses the importance of accountability mechanisms in addressing preventable maternal mortality and morbidity.

Part I: International Legal Framework

International and regional human rights treaties provide the legal foundation for women's sexual and reproductive rights, including the rights related to safe pregnancy and childbirth. These rights have been further developed by the concluding observations, general comments and decisions of the United Nations Treaty Monitoring Bodies (TMBs). Human rights treaties and TMB jurisprudence establish that preventable maternal mortality and morbidity implicate several human rights, in particular the rights to life, the highest attainable standard of health, equality and non-discrimination, reproductive self-determination, the right to information and the right to an effective remedy.

A. The Right to Life

International and regional guarantees of the right to life require governments to safeguard individuals from arbitrary and preventable loss of life.[2] Most maternal deaths are preventable, and therefore a systematic failure by governments to provide the services needed by women to survive childbirth constitutes a violation of the right to life. Moreover, the obligation of states to

protect women's right to life in the context of pregnancy and childbirth has explicitly been recognized by international and regional bodies. For example, the Human Rights Committee (HRC), the Committee on the Elimination of Discrimination against Women (CEDAW Committee), and the African Commission on Human and People's Rights have all characterized preventable maternal mortality as a violation of women's right to life.[3] These bodies have established the link between unsafe and illegal abortion and high rates of maternal mortality, and have asked states to ensure that women are not forced to undergo clandestine abortions that endanger their lives. [4]

B. The Right to Health

The fundamental right to the highest attainable standard of health is recognized in various international and regional human rights treaties,[5] and encompasses the right to sexual and reproductive health.[6] The Committee on Economic, Social and Cultural Rights (CESCR Committee) has explained that the right to health consists of both freedoms and entitlements: "freedoms include the right to control one's health and body, including sexual and reproductive freedom," and "entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[7] The CESCR Committee has further stated that an essential component of the right to health is the availability, accessibility, and quality of health facilities, goods and services.[8] Women's right to health is therefore violated when governments do not provide them with reproductive health care services that meet these standards.

International and regional human rights instruments and bodies have established states' obligations regarding the provision of the quality health care services women need for safe pregnancy and childbirth. For example, the International Covenant on Economic, Social and Cultural Rights (ICESCR) article 10(2) guarantees special protection for women during a reasonable period before and after childbirth,[9] and article 15(1)(b) guarantees to all the right to enjoy the benefits of scientific progress and its applications.[10] The CESCR Committee has established that to improve maternal health, states must take measures to provide access to family planning, pre- and post-natal care, and emergency obstetric care (EmOC).[11] The CEDAW Committee, the Committee on the Rights of the Child, and the CESCR Committee have all emphasized that women and girls also have the right to information on family planning services,[12] and the Committee Against Torture has established that they have the right to access post-abortion care.[13] CEDAW article 12(2) requires States to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal-period, granting free services where necessary,"[14] and the CEDAW Committee has emphasized that states must "ensure women's right to safe motherhood and emergency obstetric services."[15] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) also requires states to: provide adequate, affordable, and accessible health services to

women; establish and strengthen ante-natal, delivery, and post-natal health and nutrition services for women during pregnancy; and to authorize abortion in enumerated cases, which include when the pregnancy endangers the mental and physical health of the pregnant woman.[16]

C. The Right to Equality and Non-Discrimination

The right to equality and non-discrimination, regardless of gender, race, or other status, is protected under international and regional human rights law.[17] Because only women require health care services for pregnancy and childbirth, systematic government failure to provide such services reflects the devaluation of women in society and constitutes discrimination on the basis of gender. Indeed, CEDAW explicitly prohibits discrimination against women in all fields, including health care,[18] and the CEDAW Committee has found that it is discriminatory for states to criminalize or refuse to legally provide certain reproductive health services for women.[19]

Furthermore, governments are obliged under international law to ensure that women do not face discrimination on the basis of age, income, race, ethnicity, HIV status or any other condition when accessing health care services.[20] Most of the TMBs have noted that rural,[21] poor,[22] indigenous,[23] Afro-descendent,[24] and ethnic and religious minority women[25] often face additional obstacles to accessing reproductive health care, and have expressed concern that these groups have disproportionately higher maternal mortality rates than the general population.[26] The CESCR Committee has stated that strategies for promoting women's health are needed to eliminate discrimination against women, and should include high quality and affordable sexual and reproductive health services and have the goal of reducing maternal mortality.[27] TMBs have also emphasized that states must ensure that adolescents are able to access sexual and reproductive health services, [28] since a lack of resources and education, among other barriers, often prevent adolescents from obtaining needed care. It has also stated that "unequal access by adolescents to sexual and reproductive health information and services amounts to discrimination."[29]

D. The Right to Reproductive Self-Determination (the right to determine the number of spacing of children, and the rights to liberty, personal integrity and privacy)

Women's right to reproductive self-determination finds legal support in international guarantees of the right to determine the number and spacing of children[30] and the rights to liberty, personal integrity and privacy. [31] The right to determine the number and spacing of children is based on recognition of the overall impact of childbearing and rearing on women's physical and mental health, as well as women's access to education, employment, and other activities related to their personal development.[32] Government failure to provide reproductive health services in connection with pregnancy and childbirth violates women's rights to reproductive self-determination because it denies them the freedom and ability to safely control their family life, in

particular the number and spacing of children. Moreover, women without the means to control their fertility are more likely to experience unwanted pregnancies and have multiple births at shorter intervals, making them more vulnerable to the risks of maternal mortality and morbidity.

E. The Right to Information

The right to information is protected under international and regional human rights law and is a necessary part of women's ability to make choices with respect to their sexual and reproductive lives and to access health services needed to ensure healthy pregnancy and delivery. CEDAW establishes that states must provide "access to the information, education, and means" to enable women to decide freely and responsibly on the number and spacing of their children.[33] The Child Rights Committee has emphasized that states "should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)."[34]

F. The Right to an Effective Remedy

International and regional human rights law requires states to provide legal remedies and redress for human rights violations.[35] The CEDAW Committee has noted that the obligation of states to protect women's right to health care includes "put[ting] in place a system that ensures effective judicial action."[36] The CESCR Committee has likewise recognized the rights of victims of violations of the right to health to access judicial or other remedies and adequate reparation in the form of restitution, compensation, satisfaction or guarantees of non-repetition.[37] Similarly, the HRC has emphasized that states must ensure "accessible and effective remedies" for human rights violations and to take into account "the special vulnerability of certain categories of person."[38] Furthermore, it has noted that "a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant."[39] Failure to provide an effective remedy for violations of women's rights in connection with pregnancy and childbirth therefore constitutes an additional violation of their rights, and increases the likelihood that such abuses, which contribute to greater levels of maternal mortality and morbidity, will continue to occur with impunity.

G. Immediate Effect of State Obligations to Prevent Maternal Mortality

International human rights treaties and their interpretations by human rights bodies have made clear that many of the obligations states must undertake to prevent maternal mortality and morbidity are of immediate effect. While ICESCR recognizes that many of the rights it guarantees are subject to "progressive realization," and requires states to take steps to achieve those rights to the maximum of their available resources, [40] ICESCR also imposes certain "core

obligations" that are of immediate effect.[41] The CESCR Committee has emphasized that "a State Party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations…which are non-derogable."[42] The CESCR Committee has stated that the provision of maternal health services is comparable to a core obligation,[43] and that states have the immediate obligation to take "deliberate, concrete and targeted steps" towards fulfilling the right to health.[44] Furthermore, the CESCR Committee has established that non-discrimination is an obligation of immediate effect[45] and, as described earlier, systematic government failure to address maternal mortality constitutes gender discrimination. CEDAW also establishes that state obligations to address maternal mortality are of immediate effect, since CEDAW requires State parties to "ensure" services for maternal health and to "ensure" equality in access to health services.[46] International law scholars have argued that the obligations to "ensure" are more immediate in character and not subject to the qualification of progressive realization, in contrast to obligations to "recognize."[47]

Part II: Factors Contributing to Maternal Mortality

Maternal mortality has a number of direct and indirect medical causes. The most common direct medical causes are hemorrhage, obstructed labor, infection (sepsis) and hypertensive disorders related to pregnancy, such as eclampsia.[48] These conditions are largely preventable and, once detected, they are treatable. Complications from unsafe abortion are another common and preventable direct cause of maternal death.[49] Indirect causes – conditions or diseases that can lead to complications in pregnancy or are aggravated by pregnancy – include anemia, malaria and HIV/AIDS.[50]

At the same time, the medical causes of maternal mortality are often rooted in structural barriers that prevent women from accessing the care and services they need. These issues include socio-economic exclusion and discrimination, health system failures, and policy failures that are linked to human rights violations.

A. Socio-Economic Exclusion and Discrimination

The failure of states parties to ensure women's access to maternal health care is indicative of entrenched societal discrimination against women generally. At the same time, certain groups of women are particularly vulnerable to maternal mortality and morbidity due to their status in society. These women face double discrimination[51] in accessing maternal health care. This section examines the various socio-economic factors that increase women's vulnerability to mortality and morbidity during childbirth.

Poverty

In many countries, maternal mortality rates are highest in regions that also have high poverty levels and largely rural populations. For example, in India, the estimated maternal mortality rates in poor, rural states are significantly higher than the estimated rates at the national level.[52]

Poverty contributes to maternal mortality in a number of ways. First, the high cost of reproductive health services discourages women with limited economic resources from accessing family planning, antenatal care or skilled delivery.[53] Even government waiver systems, introduced in many countries to provide free family planning or maternal health care services, are often ineffective because they are not consistently implemented and women continue to be charged informal user fees.[54]

Second, women often face discrimination and other human rights violations at health facilities based on their socio-economic status. In Kenya, for example, the Center has documented cases where women who were unable to pay for services received partial or no care, were abused by staff during the provision of care, or were forcibly detained in the health facility after receiving care until payment was made.[55] These practices are not unique to Kenya. They take place around the world and violate a woman's rights to dignity and not to be subjected to cruel, degrading and inhuman treatment.[56]

Finally, inadequate public funding for health services can limit available services, particularly in poor regions of a country. In Brazil, for example, the transfer of federal funds to states and municipalities tends to favor richer states, and these discriminatory funding patterns have been connected to a lack of accessible, quality health services in poorer regions.[57] These situations violate low-income women's right to health, since health care must be both accessible and affordable for all no matter their geographic location or socio-economic status.[58]

Underlying determinants of health

Poor and marginalized populations are also less likely to have access to non-medical goods and services that are essential for good health generally and maternal health specifically. These underlying determinants of health include, among others: access to nutrition, clean water and proper sanitation; participation in health-related decision making; and information on sexual and reproductive health.[59] TMBs have repeatedly found that everyone has the right to access these underlying determinants of health.[60]

Non-discrimination and gender equality in society, or the lack thereof, are also determinants of women's health. Systematic discrimination against women in society—including denials of property and inheritance rights, marginalization in the workforce, and subjugation in the

family—leaves women with fewer economic resources, and makes it more difficult for women to access food, nutrition, and health care throughout their lives.[61] This may prevent women from accessing reproductive health care, and leave them more vulnerable to pregnancy-related health complications.

Access to education is another important determinant of health. Around the world, women's low rates of literacy and education strongly correlate to high rates of maternal mortality as well as other indices of maternal health, including fertility rate, utilization of prenatal care, met need for contraception and higher age at first birth.[62] Lack of education adversely affects women's health by limiting their knowledge of nutrition, birth spacing, and contraception.[63] Additionally, in some countries, education can be a key determinant of quality of care, with less educated women facing greater discrimination within health care facilities.[64]

Adolescents

Adolescent girls are particularly vulnerable to pregnancy and childbirth-related harm; in fact, complications during or post-pregnancy are the leading cause of death for young women and girls between the ages of 15 and 19 in developing countries.[65] These risks are linked both to the physical immaturity of adolescent girls as well as to the barriers that adolescents face in accessing reproductive health services and information.[66] TMBs have widely acknowledged that access to accurate, comprehensive reproductive health services and information is vital to empowering adolescents to make decisions that protect their health,[67] and therefore required under human rights treaty obligations.

Discrimination based on social or ethnic group

Women from certain social classes or ethnic groups often face discrimination in accessing health and other social services on the basis of their social status. In India, for example, studies show that while certain disadvantaged castes make up 16% of India's population, they represent at least 25% of all maternal deaths.[68] In Brazil, Afro-descendant populations also have less access to contraceptives, more pregnancies and higher rates of maternal death than non-Afro-descendant women.[69] Women from disadvantaged or stigmatized groups generally have limited access to resources, education, routine preventive health care, nutrition and decent living conditions, which increases their vulnerability to maternal mortality and morbidity.[70]

Discrimination against HIV-positive women

HIV-positive women require skilled care to minimize HIV-related complications during pregnancy, delivery and post-natal recovery, and to minimize the risk of HIV transmission from mother to child.[71] However, they often receive sub-standard maternal health care – or are denied

care altogether – because of their HIV status. In some cases, medical staff may refuse to provide HIV-positive women with maternal care because they do not have supplies to protect themselves from infection during the procedure.[72] Health care workers may also subject HIV-positive women to overt abuse and violence by withholding contraceptives, reprimanding them for bearing children, and turning them away from public health facilities.[73] In India, a pregnant 30-year old mother of four named Gita Bai was turned away from a public hospital and forced to give birth on the street because she was HIV-positive. She later died of excessive bleeding and sepsis.[74]

Discrimination based on health status, including HIV status, is expressly prohibited under international human rights obligations.[75] TMBs have also repeatedly acknowledged the difficulties that women from disadvantaged groups face in accessing maternal and other reproductive health services,[76] and they have recommended that states parties take additional measures to ensure that these women are able to access care. [77]

Harmful traditional practices

A number of harmful traditional practices increase women's and girls' risk of maternal mortality and morbidity. Female genital mutilation, for example, can increase a woman's risk of maternal mortality and morbidity as scar tissue from the procedure can contribute to obstructed labor and excessive bleeding during delivery.[78] Child marriage and early pregnancy is also linked both directly and indirectly to high rates of maternal death and morbidity worldwide.[79] TMBs have explicitly condemned harmful traditional practices such as child marriage and FGM, and have noted the link between such practices and maternal mortality and morbidity.[80]

B. Failures within Health Care Systems

Inadequate access to family planning information and services and access to safe abortion

UNFPA estimates that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services.[81] Women lack access to family planning services for a number of reasons, including high cost of services;[82] decisions by health care staff not to provide comprehensive information and services to patients;[83] and discrimination against women who try to access services.[84] Government policies often work to limit or deny access to contraceptives as well. In the Philippines, for example, the Center found that a ban on modern contraceptives in Manila City's public health facilities has effectively blocked access to contraceptives for the majority of the city's population, particularly low-income women.[85]

Women who cannot access family planning services often face unwanted pregnancies.[86] Women denied access to legal abortion often undergo unsafe abortions, which carry a high risk of maternal mortality and morbidity. Nigeria, for example, where abortion is only permitted to save a woman's life, has one of the highest rates of maternal mortality in the world,[87] and it is estimated that unsafe abortions lead to 34,000 maternal deaths each year.[88] Estimates also suggest that for every maternal death caused by an unsafe abortion in Nigeria, there are 30 cases of long-term injury and disability.[89]

Moreover, women often need post-abortion care to prevent death or lasting injury, but they may decide not to seek it for fear of being reported to the authorities. Health care workers may also delay care if they suspect a woman has undergone an abortion. In Kenya, for example, the Center documented the case of a woman who reported to a hospital to receive care for a miscarriage only to be suspected of having an abortion. The staff refused to treat her until she would "admit" to having an abortion, and she later died of related complications.[90]

Financial, infrastructural and institutional barriers to quality care

Women face financial, infrastructural and institutional barriers that delay or prevent access to quality maternal health care services. These barriers start at the community level, as women often live long distances from health care facilities and lack access to reliable and affordable transportation.[91] Human rights and public health standards obligate states parties to improve the accessibility of maternal health services, including by ensuring that there are a sufficient number of well-distributed health centers that provide basic and comprehensive EmOC services.[92] The CESCR Committee, for example, has interpreted accessibility of health care to require governments to ensure that medical services "are within safe, physical reach, including in rural areas."[93]

Conditions at health care facilities can further threaten a pregnant woman's health. These include long waiting periods, even in emergency situations,[94] and staff who lack the skills and training to deal with obstetric complications.[95] Health facilities may be dangerously understaffed or lack essential medicines, supplies and equipment.[96] In obstetric emergencies, a dysfunctional referral system and lack of reliable transportation can prevent a woman from accessing a facility that is equipped to provide EmOC services.[97] These barriers violate women's right to health. For example, the CESCR Committee has explicitly stated that health care facilities must be sanitary, staffed with skilled personnel, and stocked with adequate drugs and equipment, among other requirements.[98]

The damage caused by these barriers is demonstrated in the case of Alyne da Silva Pimentel, an Afro-Brazilian woman and a resident of one of Rio de Janeiro's poorest districts. Alyne faced repeated delays in receiving access to emergency obstetric care when she was six months

pregnant and needed induced delivery and post-delivery care to prevent a life threatening complication. The delays prevented Alyne from receiving the care she needed and lead to her death, which was preventable.[99]

C. Policy Failures

The barriers to maternal health care discussed above are closely linked to broader failures of policy and good governance at the state and local levels.

Lack of comprehensive policies and implementation

High rates of maternal mortality are often exacerbated by government failures to either enact comprehensive sexual and reproductive health laws and policies or to adequately implement these policies. Moreover in many cases, oversight mechanisms for maternal health care services are not in place or are inadequately implemented. In Nigeria, for example, there are no policies or laws that require the compulsory and confidential reporting and documentation of maternal deaths, data that is essential to tracking patterns of maternal mortality and formulating effective policy interventions.[100]

Resource allocation and corruption

Systematic under-funding of public maternal health services plays an important role in maternal mortality and morbidity as it often results in a lack of adequate health facilities, trained staff, and equipment and supplies necessary to provide EmOC services. Funding shortages also undermine fee waiver systems as health care providers will be more likely to charge informal fees to cover short falls in equipment, supplies and salaries.[101]

Lack of proper resource allocation is often connected to systemic corruption within health care systems. This corruption originates from both public and private actors and takes many forms, including the diversion of public funds for private use by high-level government officials, marketing of fake drugs by pharmaceutical companies, and demands for informal payments by health care providers.[102] Lack of transparency and restricted freedom of information can also prevent the public from holding states parties accountable for how public funds are spent – including their failure to adequately fund maternal health services.[103]

Part III: Importance of Accountability Mechanisms

Accessible, transparent, and effective mechanisms are fundamental to improving the existing policies and programs to reduce maternal mortality and morbidity. Such mechanisms can include a range of institutions and processes, ranging from impact assessments and policy

review, to legislative processes and courts. [104] They should be used to clarify who is responsible for what and whether needed actions have been taken, and can also support those responsible in meeting their obligations. [105]

Moreover, accountability mechanisms should provide women with redress when their rights to accessible, affordable and quality health services are violated. These mechanisms do not exist or do not function properly in many countries. Even where they are in place, patients often fail to gain redress because they do not know their rights or how to access redress mechanisms or they receive hostile responses from medical staff when they try to educate themselves about their rights.[106] Oversight mechanisms may also lack sufficient staff and funding to process complaints in a timely manner.[107]

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The legal framework governing maternal mortality and morbidity discussed in Part I makes it clear that states have a legal obligation to prevent violations of women's rights in connection with pregnancy, delivery, and recovery. This involves eliminating the barriers described in Part II and establishing adequate accountability mechanisms as described in Part III in order to effectively end preventable maternal mortality and morbidity.

[1] Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. WORLD HEALTH ORGANIZATION (WHO), ICD-10 INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS: TENTH REVISION 98 (2004). Maternal morbidity includes pregnancy- and childbirth-related illness and injury. United Nations Population Fund (UNFPA), Maternal Health, http://www.unfpa.org/swp/2004/english/ch7/page3.htm (last visited Nov. 12, 2009).

[2] Human Rights Committee, *General Comment 6: The Right to Life*, para. 5 (1982); *See also, Tavares v. France*, App. No. 16593/90, Eur. Comm'n H.R. Dec. & Rep. (Sept 12, 1991) (unreported) (finding that Article 2 of the European Convention, the right to life, means not only that the state has to abstain from intentional killing, but also that it must take the necessary measures to protect life).

[3] *See, e.g.*, Human Rights Committee, *General Comment 28: Equality of Rights between Men and Women*, para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000); Human Rights Committee: Mali, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) (expressing concern for the high rates of maternal and infant mortality and stating that the state should strengthen efforts in this regard so as to guarantee the right to life); Guatemala, para. 19, U.N. Doc. CCPR/CO/72/GTM (2001) (finding that states must gurantee the right to life of pregnant women who decide to interrupt their pregnancy); Hungary, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002) (expressing concern at the high maternal mortality rate and therefore finding that the state should take steps to protect women's life and health); *see also* Committee on the Elimination of Discrimination Against Women [*hereinafter* CEDAW Committee]: Belize, para. 56, U.N. Doc. A/54/38 (1999) (noting that "the level of maternal mortality due to clandestine abortions may

indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens"); Colombia, para. 393, U.N. Doc. A/54/38 (1999); Dominican Republic, para. 337, U.N. Doc. A/53/38 (1998) (stating that "the Committee believes that legal provisions on abortion constitute a violation of the rights of women to health and life…"); *see also,* African Commission on Human and Peoples' Rights, *ACHPR/Res. 135.08: Resolution on Maternal Mortality in Africa,* 44th ordinary sess. (2008) (stating that "preventable maternal mortality is a violation of the rights to life, health and dignity of women in Africa").

[4] *See, e.g.*, HRC: Mali, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) (expressing concern about the high maternal mortality rate due in part to the practice of clandestine abortions, and asking the State party to ensure that women are not forced to undergo clandestine abortions so as to guarantee the right to life); Guatemala, para. 19, U.N. Doc. CCPR/CO/72/GTM (2001) (finding the criminalization of all abortion, in light of the impact on maternal mortality of clandestine abortions, to be problematic, and that the "State party has the duty to adopt the necessary measures to gurantee the right to life (art. 6) of pregnant women who decide to interrupt their pregnancy"); CEDAW Committee: Belize, para. 56, U.N. Doc. A/54/38 (1999) (noting that "the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens"); Dominican Republic, para. 337, U.N. Doc. A/53/38 (1998) (stating that "the Committee believes that legal provisions on abortion constitute a violation of the rights of women to health and life…"); *see also,* Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14.2(c) [*hereinafter* Maputo Protocol].

[5] *See, e.g.,* Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, art. 25, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948) [*hereinafter* Universal Declaration]; Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, arts. 12, 14.2(b), G.A. Res. 34/189, UN GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [*hereinafter* CEDAW]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 6(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), [hereinafter CESCR]; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24(1) G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 6(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), [*hereinafter* CESCR]; Organization of American States, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"),* 16 November 1999, A-52, art. 10 [*hereinafter* Protocol of San Salvador]; Maputo Protocol, *supra* note 4, *at* art. 14.

[6] Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health,* (22nd Sess., 2000), para. 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *General Comment 14*].

[7] *Id.*

[8] *Id., at* para. 12 (stating that accessibility consists of non-discrimination, physical accessibility, affordability, and access to information). The U.N. Special Rapporteur on the right to health has affirmed these necessary components of the right to health. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 68, 71, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007).

[9] CESCR, *supra* note 5, *at* art. 10(2).

[10] CESCR, *supra* note 5, *at* art. 15(1)(b); Additionally, the Human Rights Council has recognized that preventable maternal mortality requires effective promotion and protection of the rights of women and girls to enjoy the benefits of scientific progress, among other rights. *See* Human Rights Council, 11th Sess., *Promotion and Protection of all human rights, civil, political, economic, social, and cultural rights, including the right to development: preventable maternal mortality and morbidity and human rights,* A/HRC/11/L.16/Rev.1 (June 16, 2009).

[11] CESCR, *General Comment No. 14*, *supra* note 6, *at* para. 14.

[12] *See, e.g.*, CEDAW Committee: Cape Verde, para. 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); Togo, para. 28, U.N. Doc. CEDAW/C/TOG/CO/5 (2006); Romania, paras. 24–25, U.N. Doc. CEDAW/C/ROM/CO/6 (2006); Committee on the Rights of the Child: Cambodia, para. 52, U.N. Doc. CRC/C/15/Add.128, (2000); Colombia, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); Grenada, para. 22, U.N. Doc. CRC/C/15/Add.121 (2000); Maldives, para. 19, U.N. Doc. CRC/C/15/Add.91 (2998); Committee on Economic, Social and Cultural Rights: Russian Federation, para. 63, U.N. Doc. E/C.12/1/Add.94 (2003); Benin, paras. 23, 42, U.N. Doc. E/C.12/1/Add.78 (2002); Mexico, para. 44, U.N. Doc. E/C.12/MEX/CO/4 (2006); Senegal, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001).

[13] *See* Committee against Torture: Chile, para. 4(h), U.N. Doc. CAT/CR/32/5 (2004); Human Rights Committee: Chile, para. 15, U.N. Doc. CCPR/C/79/Add.104 (1999).

[14] CEDAW, *supra* note 5, *at* art. 12(2).

[15] CEDAW Committee, *General Recommendation 24: Women and Health (art. 12),* para. 27, 20th Sess. (1999) [hereinafter CEDAW, *General Recommendation 24*].

[16] Maputo Protocol, *supra* note 4, *at* art. 14(2).

[17] *See, e.g.*, ICCPR, art. 2, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [*hereinafter* ICCPR]; CESCR, *supra* note 5, *at* art. 2(2); CEDAW, *supra* note 5, *at* art. 1; CRC, *supra* note 5, *at* art 2(1); Maputo Protocol, *supra* note 4, *at* art. 2(1); American Convention on Human Rights, *adopted* Nov. 22, 1969, art. 1(1), O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978), *available at* http://www.cidh.oas.org/Basicos/English/Basic3.American%20Convention.htm (last visited Sept. 25, 2009) [*hereinafter* American Convention]; Protocol of San Salvador, *supra* note 5, *at* art. 3; Convention for the Protection of Human Rights and Fundamental Freedoms, *adopted* Nov. 4, 1950, art. 14, 213 U.N.T.S. 222, Europ. T.S. No. 5 (*entered into force* Sept. 3, 1953) [*hereinafter* European Convention on Human Rights]; Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, Explanatory Report, Nov. 4, 2000, Europ. T.S. No. 177.

[18] CEDAW, *supra* note 5, *at* art. 12(1).

[19] CEDAW, *General Recommendation 24*, *supra* note 15, *at* paras. 11, 14.

[20] *See, e.g,* CESCR Committee, *General Comment 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2),* paras. 29, 33, 35 UN Doc. E/C.12/GC/20 (2009) [hereinafter CESCR, *General Comment 20*].

[21] *See, e.g.*, CEDAW Committee: Kazakhstan, para. 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007); Kenya, para. 38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007); Laos People's Democratic Republic, para. 96, U.N. Doc. A/60/38 (2005); Morocco, para. 32, U.N. Doc. CEDAW/C/MAR/CO/4 (2008); Committee on the Rights of the Child: Eritrea, para. 53, U.N. Doc. CRC/C/ERI/CO/3 (unedited version) (2008); Mali, para. 50, U.N. Doc. CRC/C/MLI/CO/2 (2007); Tunisia, para. 37, U.N. Doc. CRC/C/15/Add.181 (2002); Human Rights Committee: Argentina, para. 14, U.N. Doc. CCPR/CO/70/AR G (2000); Committee on Economic, Social and Cultural Rights: Benin, para.25, U.N. Doc. E/C.12/BEN/CO/2 (2008); Columbia, para. 24, U.N. Doc. E/C. 12/1/Add.74 (2001); Japan, para. 55, E/C.12/1/Add.67 (2001); Mexico, para. 44, U.N. Doc. E/C.12/MEX/CO/4 (2006).

[22] *See, e.g.*, CEDAW Committee: Bangladesh, para. 438, U.N. Doc. A/52/38/Rev.1, Part II (1997); Hungary, para. 329, U.N. Doc. A/57/38 (2002); Mexico, para. 394, U.N. Doc. A/53/38 (1998); South Africa, para. 134, U.N. Doc. A/53/38/Rev.1 (1998); Human Rights Committee: Argentina, para. 14, U.N. Doc. CCPR/CO/70/AR G (2000); Committee on Economic, Social and Cultural Rights: Peru, para. 16, U.N. Doc. E/C.12/Add.1/14 (1997).

[23] *See, e.g.*, CEDAW Committee: Australia, para. 397, U.N. Doc. A/52/38/Rev.1, Part II (1997); New Zealand, para. 279, U.N. Doc. A/53/38 (1998); Peru, para. 341, U.N. Doc. A/53/38/Rev.1 (1998); Committee on Economic, Social and Cultural Rights: Peru, para. 16, U.N. Doc. E/C.12/Add.1/14 (1997).

[24] See, e.g., CEDAW Committee: Colombia, para. 22, CEDAW/C/Col/CO/6 (2007); Brazil, para. 126, A/58/38 (2003).

[25] *See, e.g.*, CEDAW Committee: Israel, para. 162, U.N. Doc. A/52/38 Rev.1, Part II (1997); Human Rights Committee: Ireland, paras. 27–28, U.N. Doc. A/55/40 (2000); Committee on the Elimination of Racial

Discrimination: India, para. 24, U.N. Doc. CERD/C/IND/CO/19 (2007); Slovakia, para. 14, U.N. Doc. CERD/C/304/Add.110 (2001); Vietnam, para. 10, U.N. Doc. CERD/C/59/Misc.21/Rev.3 (2001).

[26] *See, e.g.*, Committee on the Elimination of Racial Discrimination: India, para. 24, U.N. Doc. CERD/C/IND/CO/19 (2007); Nicaragua, para. 23, U.N. Doc. CERD/C/NIC/CO/14 (2008); United States, para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008).

[27] CESCR, *General Comment No. 14*, *supra* note 6, *at* para. 21.

[28] *See, e.g.*, CEDAW Committee: Chile, para. 227, U.N. Doc. A/54/38 (1999); Greece, paras. 207–08, U.N. Doc. A/54/38 (1999); Ireland, para. 186, U.N. Doc. A/54/38 (1999); Nigeria, para. 171, U.N. Doc. A/53/38/Rev.1 (1998); Human Rights Committee: Ecuador, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998).

[29] *See, e.g.*, CESCR, *General Comment 20*, *supra* note 20, *at* para. 29.

[30] CEDAW, *supra* note 5, *at* art. 16.1; *see also*, *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).

[31] *See, e.g.*, ICCPR, art. 9 ("Everyone has the right to liberty and security of the person…"), art. 17.1 ("No one shall be subject to arbitrary or unlawful interference with his privacy.."); CCPR, *General Comment 20: Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment*, para. 2, U.N. Doc. HRI/GEN/1/Rev.7 (1992) (stating that the aim of ICCPR art. 7 is "to protect both the dignity and the physical and mental integrity of the individual").

[32] CEDAW Committee, *General Recommendation 21: Equality in Marriage and Family Relations*, para 21, 13th Sess. (1994) [*hereinafter* CEDAW, *General Recommendation 21*].

[33] CEDAW, *supra* note 5, *at* art. 16(1)(e).

[34] Committee on the Rights of the Child, *General Comment 4: Adolescent health and development in the context of the Convention of the Rights of the Child*, para. 28, U.N. Doc. CRC/GC/2003/4 (2003).

[35] *See, e.g.*, UN General Assembly, *Note by the Secretary-General: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 13 September 2006, A/61/338, para. 28(d) (stating that "[m]onitoring and accountability are integral features of the right to health and can help reduce maternal mortality").

[36] CEDAW, *General Recommendation 21*, *supra* note 32, *at* para. 21.

[37] CESCR, *General Comment 14*, *supra* note 6, *at* para. 59.

[38] Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation on States Parties to the Covenant*, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add/13 (2004) [*hereinafter* HRC, *General Comment 31*].

[39] *Id.*

[40] CESCR, *supra* note 5, *at* art. 2(1).

[41] CESCR *General Comment 14*, *supra* note 6, *at* para. 44.

[42] *Id.*, para 47.

[43] *Id.*, paras. 43, 44(a).

[44] *Id.*, para 30.

[45] *See, e.g*, CESCR, *General Comment 20*, *supra* note 16, *at* para. 7 (stating "Non-discrimination and equality are fundamental components of international human rights law and essential to the exercise and enjoyment of economic, social and cultural rights").

[46] CEDAW, *supra* note 5, *at* art. 12.

[47] *See* Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations under the ICESCR*, 9.2 Hum. Rts. Q. 185, 186 (1987); *see also* HRC, *General Comment 31*, *supra* note 38, *at* para. 5.

[48] WORLD HEALTH ORGANIZATION (WHO), *Health Topics – Maternal Mortality*, *available at* http://www.who.int/topics/maternal_health/en/ (last accessed on Dec. 3, 2009).

[49] *See* UNFPA, EMERGENCY OBSTETRIC CARE: CHECKLIST FOR PLANNERS 1 (2002), *available at* http://www.unfpa.org/upload/lib_pub_file/150_filename_checklist_MMU.pdf (*last accessed on* Nov. 16, 2009)*; see also* World Health Organization (WHO), *Maternal Mortality Fact Sheet*, WHO/MPS/08.12, *at*

http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_maternal_mortality.pdf (last accessed on Nov. 16, 2009) [*hereinafter* WHO, *Maternal Mortality*].

[50] *See* WHO, *Maternal Mortality*, *supra* note 49, *at* 1.

[51] Double discrimination refers to discrimination based simultaneously on more than one ground, for example, discrimination based on both gender and race. TMBs have recognized double discrimination as a distinct form of discrimination. *See, e.g.*, Committee on the Elimination of Racial Discrimination, *General Recommendation XXVII: Discrimination against Roma* (57th Sess., 2000), in Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.5; CERD Committee, *Concluding Observations: Uruguay*, para. 10., U.N. Doc. CERD/C/304/Add.78 (2001).

[52] *See* THE CENTER FOR REPRODUCTIVE RIGHTS, MATERNAL MORTALITY IN INDIA: USING INTERNATIONAL AND CONSTITUTIONAL LAW TO PROMOTE ACCOUNTABILITY AND CHANGE 11-12 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_br_maternal_mortality_in_india_2009.pdf [*hereinafter* MATERNAL MORTALITY IN INDIA].

[53] WOMEN ADVOCATES RESOURCE AND DOCUMENTATION CENTRE (WARDC) AND THE CENTER FOR REPRODUCTIVE RIGHTS, BROKEN PROMISES: HUMAN RIGHTS, ACCOUNTABILITY, AND MATERNAL DEATH IN NIGERIA 40 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_nigeria2.pdf [*hereinafter* BROKEN PROMISES].

[54] *Id., at* 41-44; *See also* FEDERATION OF WOMEN LAWYERS – KENYA (FIDA-KENYA) AND THE CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES, 16-17 AND 54-55 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [*hereinafter* FAILURE TO DELIVER].

[55] *See* FAILURE TO DELIVER, *supra* note 54.

[56] *See* BROKEN PROMISES, *supra* note 53; MATERNAL MORTALITY IN INDIA, *supra* note 52.

[57] *See* OECD, *Economic Survey of Brazil 2005: Better Targeting Government Social Spending* 9 (2004), *available at* http://www.oecd.org/dataoecd/12/10/34427527.pdf (*last visited on* Nov. 16, 2009); *see also* ANDRE CEZAR MEDICI, *Financing Health Policies in Brazil: Achievements, Challenges and Proposals* 7 (Inter-American Development Bank 2002), *available at* http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=354036 (*last visited on* Nov. 16, 2009); *See* WORLD BANK, *Brazil: Maternal and Child Health*, para. 1.31 at 15, Report No. 23811-BR (2002).

[58] *See e.g.*, CESCR, *General Comment 14*, *supra* note 6, *at* para. 12(b).

[59] *See* UN General Assembly, *Note by the Secretary-General: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* 13 September 2006, A/61/338, para. 18 [*hereinafter Note by the Secretary General*].

[60] *See, e.g.*, CESCR, *General Comment 14*, *supra* note 6, *at* paras. 11, 14; *Note by the Secretary-General*, *supra* note 59, *at* para. 18; on the right to information, *see* CEDAW, *General Recommendation 24*, *supra* note 15, *at* para. 23; CRC, *General Comment 4*, *supra* note 34, *at* para. 26.

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[62] Chryssa McAlister and Thomas Baskett, *Female Education and Maternal Mortality: A Worldwide Survey*, 28 J. Obstetrics & Gynecology Canada 983, 988-989 (2006), *available at* http://www.sogc.org/jogc/abstracts/full/200611_WomensHealth_3.pdf ("the female literacy rate [as a percentage of the male literacy rate]…is a moderately powerful predictor of maternal mortality with a negative correlation….This relationship also holds true for the combined education enrolment ratio variable that looks at the percentage of females enrolled in primary, secondary, and tertiary levels of education. It is not surprising that maternal mortality is correlated with a discrepancy in education levels between males and females. Education gives women the knowledge to demand and seek proper health care."); Chandrakant Lahariya and Jyoti Khandekar, *How the findings*

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[64] Manju Rani, et al., *Differentials in the quality of antenatal care in India*, International Journal for Quality in Health Care 8 (2007).

[65] UNFPA, STATE OF THE WORLD POPULATION: THE CAIRO CONSENSUS 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.

[66] Committee on the Rights of the Child: Cambodia, paras. 52, 53, U.N. Doc. CRC/C/15/Add.128 (2000); Colombia, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); Grenada, para. 22, U.N. Doc. CRC/C/15/Add.121 (2000); Maldives, para. 19, U.N. Doc. CRC/C/15/Add.91 (1998).

[67] *See* CESCR, *General Comment 20*, *supra* note 16, *at* para. 29; Committee on the Rights of the Child*:* Albania, para. 57, U.N. Doc.CRC/C/15/Add.249 (2005), Algeria, paras. 58, 59, U.N. Doc. CRC/C/15/Add.269 (2005); Djibouti, para. 46, U.N. Doc. CRC/C/15/Add.131 (2000); CEDAW, *General Recommendation 24*, *supra* note 15, *at* paras. 14, 18; Human Rights Committee: Ecuador, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998).

[68] MATERNAL MORTALITY IN INDIA, *supra* note 52, *at* 17.

[69] *See* Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), *Monitoring Alternative Report on the Situation of Maternal Mortality in Brazil to the International Covenant on Economic, Social and Cultural Rights*, *available at* http://www.cladem.org/english/regional/monitoreo_convenios/descMMbrasili.asp (last accessed November 16, 2009) [*hereinafter* CLADEM, *Situation of Maternal Mortality*].

[70] MATERNAL MORTALITY IN INDIA, *supra* note 52, *at* 17; *See also* CLADEM, *Situation of Maternal Mortality*, *supra* note 70.

[71] Office of the U.N. High Commissioner for Human Rights & Joint U.N. Programme on HIV/AIDS, HIV/AIDS and Human Rights International Guidelines (1998) para. 80 [hereinafter UN Human Rights Guidelines], *available at* http://www.unaids.org/html/pub/publications/irc-pub02/jc520-humanrights_en_pdf.htm (last accessed November 16, 2009).

[72] FEDERATION OF WOMEN LAWYERS – KENYA (FIDA) AND THE CENTER FOR REPRODUCTIVE RIGHTS, AT RISK: RIGHTS VIOLATIONS OF HIV-POSITIVE WOMEN IN KENYAN HEALTH FACILITIES 40-42 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/At%20Risk.pdf.

[73] *Id*., *at* 43-48; *see also* MATERNAL MORTALITY IN INDIA, *supra* note 44, *at* 17-18.

[74] ATHENA Network and the Center for Reproductive Rights, *Submission of Evidence – Hearings into Maternal Morbidity*. Submission to the United Kingdom Parliament, All Parliamentary Group – Population, Development and Reproductive Health (Submitted on 26 Sept. 2008).

[75] CESCR, *General Comment 20*, *supra* note 16, *at* para. 33.

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[77] *See e.g.*, Committee on the Rights of the Child: Cote d'Ivoire, para. 25, U.N. Doc. CRC/C/15/ Add.155 (2001); Human Rights Committee: Ecuador, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998); Ireland, para.para. 27–28, U.N. Doc. A/55/40 (2000); Committee on Economic, Social and Cultural Rights: Nepal, para. 46, U.N. Doc. E/C.12/NPL/CO/2 (2008); Paraguay, para. 28, U.N. Doc. E/C.12/1/Add.1 (1996); Peru, para. 36, U.N. Doc. E/C.12/Add.1/14 (1997).

[78] *See* CENTER FOR REPRODUCTIVE LAW AND POLICY (now THE CENTER FOR REPRODUCTIVE RIGHTS) and RAINBO, FEMALE GENITAL MUTILATION: A GUIDE TO LAWS AND POLICIES WORLDWIDE 8-9 (Zed Books 2000); *see also* Marcel Reyners, *Health Consequences of Female Genital Mutilation*, 4 REVIEWS IN GYNAECOLOGICAL PRACTICE 242 (2004).

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[80] *See, e.g.*, CESCR, *General Comment 14*, *supra* note 6, *at* para. 21; CRC, *supra* note 5, *at* art. 24(3); Eritrea, para. 45, U.N. Doc. CRC/C/15/Add.204 (2003); Human Rights Committee: Sudan, para. 10, U.N. Doc. CRC/C/79/Add.85 (1997).

[81] UNFPA, *Reducing Risks by Offering Contraceptive Services, at* http://www.unfpa.org/mothers/contraceptive.htm (last accessed November 16, 2009); World Bank, *Public Health at a Glance: Maternal Mortality* (2006), *at* http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/0,,contentMDK:20944136~menuPK:2656916~pagePK:64229817~piPK:64229743~theSitePK:672263,00.html (last accessed November 16, 2009).

[82] *See* FAILURE TO DELIVER, *supra* note 46, *at* 16-17; *see also* Center for Reproductive Rights, *International Standards on Subsidizing Contraceptives*, *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_slovak1_international%20standards_9%2008_WEB.pdf

[83] *See* FAILURE TO DELIVER, *supra* note 46, *at* 20-21.

[84] *See* BROKEN PROMISES, *supra* note 45, *at* 36.

[85] *See* LIKHAAN, REPROCEN AND THE CENTER FOR REPRODUCTIVE RIGHTS, IMPOSING MISERY: THE IMPACT OF MANILA'S BAN ON CONTRACEPTION (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Philippines%20report.pdf; *see also* BROKEN PROMISES, *supra* note 45, *at* 27-35.

[86] Family Health International, *The Importance of Family Planning in Reducing Maternal Mortality*, *at* http://www.fhi.org/en/RH/Pubs/Briefs/MCH/factsheet11.htm (last accessed on November 16, 2009).

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[91] *See* BROKEN PROMISES, *supra* note 45, *at* 49.

[92] *See* WORLD HEALTH ORGANIZATION, ET AL., MONITORING EMERGENCY OBSTETRIC CARE: A HANDBOOK (2009), *available at* http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf (last accessed November 16, 2009).

[93] CESCR, *General Comment 14*, *supra* note 6, *at* para. 12(b).

[94] *See* BROKEN PROMISES, *supra* note 45, *at* 48.

[95] *See* FAILURE TO DELIVER, *supra* note 46, *at* 44-45.

[96] *See id., at* 44-46; BROKEN PROMISES, *supra* note 45, *at* 46-48.

[97] *See* BROKEN PROMISES, *supra* note 45, *at* 49.

[98] CESCR, *General Comment 14*, *supra* note 6, *at* para. 12(d); *see also, Note by the Secretary-General*, *supra* note 51, *at* para. 13 (noting that the right to the highest attainable standard of health entitles women to care including

access to a skilled birth attendant, emergency obstetric care, and education and information on sexual and reproductive health); African Commission on Human and Peoples' Rights, *Recommendations on Addressing Maternal Mortality in Africa* (2008) (requiring states to "employ and retain skilled health personnel and birth attendants at rural and semi-urban areas; train and retain health workers in emergency obstetric care; develop community led emergency transport system to cushion the effect of delays in getting medical attention."

[99] *See* CENTER FOR REPRODUCTIVE RIGHTS, LITIGATION BRIEFING SERIES: ALYNE DA SILVA PIMENTEL (2009).

[100] *See* BROKEN PROMISES, *supra* note 45, *at* 19; *see also* FAILURE TO DELIVER, *supra* note 46, *at* 63-65; MATERNAL MORTALITY IN INDIA, *supra* note 44, *at* 22-23.

[101] *See* BROKEN PROMISES *supra* note 45, *at* 22.

[102] *See id., at* 20; *see also* MATERNAL MORTALITY IN INDIA, *supra* note 44, *at* 23.

[103] *See* BROKEN PROMISES, *supra* note 45, *at* 20-26.

[104] Paul Hunt & Judith Bueno de Mesquita, *Reducing Maternal Mortality: the contribution of the right to the highest attainable standard of health* Human Rights Centre, at 12.

[105] Paul Hunt & Judith Bueno de Mesquita, *Reducing Maternal Mortality: the contribution of the right to the highest attainable standard of health* Human Rights Centre, at 12.

[106] *See* FAILURE TO DELIVER *supra* note 46, *at* 72-74.

[107] *See id., at* 67-68.