FROM RISK TO RIGHTS

REALIZING STATES' OBLIGATIONS TO PREVENT AND ADDRESS MATERNAL MORTALITY

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Cover photo credit: World Bank
Cover photo caption: Nursing staff from surrounding clinics came to support their colleagues at Holme Eden Clinic.

Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
United States

Tel +1 917 637 3600
Fax +1 917 637 3666

publications@reprorights.org
reproductiverights.org

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During the past several decades, sexual and reproductive rights advocates have transformed the global community's understanding of maternal mortality and morbidity, framing the scores of preventable maternal deaths that occur each day as a clear violation of women's fundamental human rights. This change has resulted from the coordinated efforts of civil society to draw attention to the widespread discrimination in and lack of quality maternal health care around the globe through advocacy before human rights bodies, groundbreaking court cases, strong political declarations, and the incorporation of maternal mortality into development targets. Through cases like *Alyne da Silva Pimentel v. Brazil*, the passage of Human Rights Council resolutions, and in the Millennium Development Goals (MDGs), the Center for Reproductive Rights and other human rights and reproductive health advocates have convincingly argued that preventable maternal mortality and morbidity is a violation of women's rights to life, health, non-discrimination and equality, and freedom from cruel, inhuman and degrading treatment, among others.[1]

These critical victories have played an important role in securing the 45% decline in maternal deaths that has occurred worldwide since 1990.[2] Despite these advancements, concerted advocacy efforts must continue, as maternal mortality still claims the lives of 800 women and girls each day.[3] For each of these deaths, an additional 20-30 women and girls suffer acute or chronic morbidity, often with permanent aftereffects.[4] The most shocking part of these staggering figures is that most of these deaths are preventable.[5]

Patterns of maternal mortality reflect disparities in resources, access to health services and discrimination.[6] Ninety-nine percent of maternal deaths occur in developing countries and maternal mortality rates are considered a key indicator of disparities between developed and developing countries.[7] Even within countries that have relatively moderate or low maternal mortality rates, wide disparities in maternal mortality rates persist among populations, as groups of women who have historically been marginalized commonly experience a substantially higher likelihood of dying during pregnancy and childbirth.[8] Young women and adolescents also represent a particularly vulnerable sub-population throughout the world. Complications in pregnancy and childbirth are the leading cause of death among adolescent girls in most low-income countries.[9]

REDUCTION IN ANNUAL MATERNAL DEATHS WORLDWIDE

543,000

MATERNAL DEATHS ANNUALLY IN 1990

289,000

MATERNAL DEATHS ANNUALLY IN 2013

Source: WHO, Unicef, UNFPA and the World Bank, Trends in Maternal Mortality: 1990 to 2013, 1 (2014).

The right to survive pregnancy and childbirth is a fundamental human right and should not be contingent upon a woman's age, where she lives, or her income level. The global community has the tools to remediate the injustice that maternal death and disability wreak on individuals' and families' lives. States, international donors, United Nations (UN) agencies and members of civil society must accelerate targeted and concerted actions necessary to translate the commitments that exist on paper into the actual eradication of preventable maternal mortality and morbidity.

This publication examines the process by which preventable maternal mortality and morbidity became recognized as a violation of women and girls' fundamental human rights, focusing on the critical role sexual and reproductive rights advocates played in drawing global attention to this issue and commemorating significant milestones throughout the past two decades. To this end, this publication describes the direct and systemic causes of maternal mortality and morbidity and summarizes the international and regional human rights standards, political declarations and development commitments surrounding safe pregnancy and childbirth. It further explores the accountability mechanisms that human rights advocates have used to translate these into concrete measures to ensure women and girls' right to safe pregnancy and childbirth, provides recommendations for future action, and includes a timeline of landmark events.

KEY DEFINITIONS

- Maternal Mortality: The death of a woman during pregnancy or within 42 days of termination of pregnancy from a cause related to or aggravated by the pregnancy or its management.[10]
- Maternal Morbidity: Any health condition with a negative impact on the woman's well-being that is attributed to and/or aggravated by pregnancy and childbirth.[11]
- Maternal Mortality Ratio (MMR): The number of maternal deaths during a given time period per 100,000 live births during the same time period.[12]

UN Photo/Eskinder Debebe

II. CAUSES OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY

The most common direct causes of maternal death are severe bleeding, infections, high blood pressure (pre-eclampsia and eclampsia), complications from delivery, and unsafe abortion.[13] The social context in which these mortalities occur provide insight on the broader structural causes of maternal mortality and morbidity. The three delays model takes into account and explains the underlying and interconnected causes of maternal death.[14] This model can also be applied to maternal morbidity,[15] although the lack of standardized reporting and identification criteria for maternal morbidity prevents accurate measurement of its causes.[16]

- A **Phase I delay** occurs when a woman and/or her family delays the decision to seek health care for a pregnancy-related complication. The reasons behind these delays are complex and may include a range of factors. For instance, limited sexual and reproductive health education may make it difficult for a woman or her family to recognize that she is experiencing a life-threatening obstetric complication.[17] Poverty can also contribute to this delay, since the cost of accessing maternal health services may deter poor women from seeking timely care.[18]

- Once the decision has been made to seek care, a **Phase II delay** occurs when a woman is unable to reach a health facility in a timely fashion. Normally, this delay reflects the lack of accessible maternal health services due to infrastructural deficiencies related to distribution of facilities, roads and communication networks.[19] Research has demonstrated that women who experience higher levels of maternal mortality and morbidity are forced to travel greater distances, attempt to obtain care at more facilities, and reach an appropriate facility at later points in time.[20]

- Finally, even if a woman is able to reach a health care facility in a timely manner, she may experience a delay in receiving adequate, appropriate, and quality care. **Phase III delays** are indicative of weak health care systems and may result from shortages of trained staff and supplies, inadequate referral networks, clinical mismanagement, and negative attitudes towards women.[21]

These phases are interrelated and most maternal deaths occur following multiple forms of delay. For example, a woman living in a remote area who experiences a Phase II delay due to transportation difficulties is more likely to reach a facility in poorer condition. While the health facility may have had the resources or skill level to treat her initially, her deteriorated condition may require greater expertise, supplies or medicines than is available, which results in a further delay in the administration of the proper care.[22] Thus, the differences in the level of maternal mortality observed between high- and low-income countries and between different groups of women within countries largely result from differences in the time management of obstetric complications that occur across all three phases of delay.[23]

SOCIAL AND OTHER DETERMINANTS OF HEALTH

Far too frequently, whether women survive pregnancy and childbirth is related to their social, economic and cultural status. "Social determinants of health" refers to the conditions in which people are born, grow, live, work and age, which are shaped by power structures and resource distribution at the local, national and global levels.[24] Social and other determinants of health include both structural and intermediary factors:

- *Structural factors* determine how wealth, power and resources are distributed across social groups.[25] This includes how the legal and policy framework ensures gender equality more broadly, such as whether women and girls can make autonomous decisions about their health, as well as the social and cultural values that determine social status, social and gender norms, educational attainment, and economic empowerment.

- *Intermediary factors* establish whether and how social groups access health and social services.[26] These include the availability of and knowledge about health services, distance to health facilities, social position, family structure and decision-making, threats of violence or coercion, and control of or access to resources.

As high maternal mortality and morbidity rates are connected to and stem from gender inequalities, strategies to improve maternal health should aim to elevate the status of women and reduce disparities between different groups of women. Such measures should invest in women's social and economic development by enhancing educational attainment and empowerment, particularly for marginalized groups of women and girls. At the same time, to address the inequities in social and other determinants of health, which in turn impact women's ability to enjoy their right to safe pregnancy and childbirth, states must make broader investments in strong national health care systems, access to clean water and nutritious food, ensuring wide participation and a meaningful voice in political life, as well as access to effective means of remedy and redress, among others. Providing women and girls with greater reproductive autonomy, through measures such as preventing child, early and forced marriage; enabling girls to remain in school; and expanding women's employment opportunities, can reduce rates of maternal mortality and morbidity.[27]

III. STATES' INTERNATIONAL HUMAN RIGHTS OBLIGATIONS TO REALIZE THE RIGHT TO SAFE PREGNANCY AND CHILDBIRTH

The international human rights norms surrounding safe pregnancy and childbirth provide states concrete guidance in realizing the right to safe pregnancy and childbirth. Treaty monitoring bodies (TMBs), which oversee states' compliance with their international human rights obligations, have recognized the prevention of maternal mortality and morbidity and the right to safe pregnancy and childbirth as part of the rights to life, health, equality and non-discrimination, and freedom from cruel, inhuman and degrading treatment.[28]

Right to Life

States have a fundamental duty to protect individuals from arbitrary and preventable loss of life,[29] including from preventable maternal death.[30] The Human Rights Committee, which monitors states' compliance with the International Covenant on Civil and Political Rights, was the first treaty monitoring body to clearly indicate that states must adopt positive measures to protect the right to life, including measures to reduce mortality and increase life expectancy.[31] Since then, the Committee on the Elimination of Discrimination against Woman (CEDAW Committee), which monitors states' compliance with the Convention on the Elimination of Discrimination against Women, the Human Rights Committee and the Committee on the Rights of the Child, which monitors states' compliance with the Convention on the Rights of the Child, have all explicitly interpreted the right to life to include states' obligations to prevent and address maternal mortality.[32]

Right to Health

Treaty monitoring bodies have also squarely grounded the right to safe pregnancy and childbirth within the right to health.[33] Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), states have a core obligation to ensure the provision of medicines from the World Health Organization's Model List of Essential Medicines,[34] which includes a range of medicines for the provision of maternal health care. This includes medicines for the prevention and treatment of pre-eclampsia and eclampsia, post-partum hemorrhage, and maternal sepsis, as well as for the provision of safe abortion and management of incomplete abortion and miscarriage.[35] Core obligations are the minimum essential level of each right that states must immediately realize.[36] The Committee on Economic, Social and Cultural Rights (ESCR Committee), which monitors states' compliance with the ICESCR, has explicitly indicated that states' obligations to guarantee maternal health care – which includes pre-natal and post-natal care – is comparable to a core obligation under the right to health.[37] As such, the provision of pre-natal and post-natal care is one of the minimum essential elements of the right to health that states must meet immediately.[38]

Right to Equality and Non-discrimination

States are obligated to eliminate discrimination against women in the area of health care in order to ensure women's equal access to health services, including those in connection with pregnancy and the post-natal period.[39] In the groundbreaking decision of *Alyne v. Brazil*, explored further below, the CEDAW Committee clearly established that states must provide quality maternal health services in order to prevent maternal mortality, including timely and appropriate maternal health services that meet the distinct needs of women and are inclusive of marginalized sectors of society.[40] TMBs have indicated that states should take targeted measures to address maternal mortality in marginalized groups that have disproportionately elevated rates of maternal death, including young women,[41] low-income women,[42] rural women,[43] women belonging to minority groups,[44] indigenous women,[45] and migrant workers.[46]

Right to Freedom from Cruel, Inhuman and Degrading Treatment

The Committee against Torture (CAT Committee), which oversees compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, has expressed concern about high maternal mortality rates, particularly those resulting from unsafe abortion, demonstrating that preventable maternal deaths may violate protections against the right to freedom from cruel, inhuman and degrading treatment.[47] The CAT Committee has also expressed concern about maltreatment of women seeking maternal health care, such as the shackling of women detainees during labor[48] and the post-delivery detainment of pregnant women who are unable to pay their medical bills.[49]

TMBs have consistently linked elevated rates of maternal mortality to lack of comprehensive reproductive health services,[50] restrictive abortion laws,[51] unsafe or illegal abortion,[52] adolescent childbearing,[53] child and forced marriage,[54] and inadequate access to contraceptives.[55] To this end, they have urged states to take specific, concrete measures to address maternal mortality and morbidity in order to realize women's right to safe pregnancy and childbirth. Such measures include:

- Providing adequate pre- and post-natal care,[56] emergency obstetric services,[57] and skilled birth attendance;[58]
- Preventing unintended pregnancy, including through the provision of sexuality education[59] and comprehensive sexual and reproductive health services, including contraception;[60]
- Preventing unsafe abortion through the liberalization of restrictive abortion laws[61] and guaranteeing women access to safe abortion services;[62]
- Ensuring maternal health services are affordable and granting free services where needed;[63]
- Allocating sufficient resources to the health sector and strengthening institutional health care capacity;[64]
- Conducting research and analysis on the causes of maternal morbidity and mortality;[65] and
- Focusing on the needs of vulnerable populations, including rural and low-income women.[66]

State Obligations: Respect, Protect, Fulfill

States have specific duties to respect, protect and fulfill the right to safe pregnancy and childbirth. These obligations include both limitations on states' actions and the positive measures that states must take.

- **Respect:** States must refrain from interfering, either directly or indirectly, with the enjoyment of the right to safe pregnancy and childbirth.
- **Protect:** States must regulate third parties interference with the right to safe pregnancy and childbirth and impose sanctions on those who violate this right.
- **Fulfill:** States must adopt legislative, budgetary, administrative, and judicial measures towards the full realization of the right to safe pregnancy and childbirth.

Availability, Accessibility, Acceptability and Quality

As part of their international human rights obligations to respect, protect and fulfill the right to safe pregnancy and childbirth, states must guarantee that reproductive health information, goods and services are available, accessible, acceptable and of good quality.[67]

- **Available**: Functioning public health and maternal health care facilities must be available in sufficient quantity within the state, meaning that they are equitably distributed and available in adequate numbers to all women and girls.[68] Availability also extends to the underlying determinants of health, such as potable drinking water, sanitation facilities, and essential drugs as defined by the WHO Model List of Essential Medicines.[69]
- **Accessible**: Maternal health care facilities should be accessible to everyone on a non-discriminatory basis, in law and in fact, especially for marginalized members of the population, such as low-income or rural women and girls. Accessibility also includes:
  - *Physical accessibility*: Primary health care and emergency obstetric services must be within physical reach for everyone, especially marginalized groups such as people with disabilities or indigenous populations. States must ensure that women are not forced to travel great distances to access maternal health care.
  - *Economic accessibility:* Maternal health facilities, goods and services must be affordable to all women and girls, regardless of whether they are publicly or privately provided. Where women are unable to afford maternal health services, the state should cover the costs.
  - *Information accessibility*: Women and girls have the right to seek, receive and impart information and ideas concerning their reproductive and sexual health. Women and girls, their families and communities must be provided with information that enables them to safely experience pregnancy and childbirth, including information on the signs of potentially dangerous obstetric complications and availability of sexual and reproductive health services.[70]
- **Acceptable**: Sexual and reproductive health care should be respectful of medical ethics and patient confidentiality, culturally appropriate, and sensitive to gender and life-cycle

requirements.[71] Reducing preventable maternal mortality is not simply about scaling up technical interventions—providers must understand and respect the knowledge, attitudes and practices toward pregnancy and childbirth of the communities in which they work, including indigenous and minority populations.

- **Quality**: The care women and girls receive during pregnancy and following birth should be scientifically and medically appropriate and of good quality, including skilled medical personnel, adequate drugs and equipment, safe and potable water, and sanitation.[72] Quality care is crucial not only because it directly impacts the frequency of maternal death and disability, but also because many women consider the quality of care they are likely to receive as more important than factors such as distance or cost.[73] Pregnant women are more likely to seek maternal health care in a facility if they have trust and confidence in the care they will receive there.[74]

LIKELIHOOD OF DYING IN CHILDBIRTH

1:18
SOMALIA

VS.

1:19,200
AUSTRIA

Source: The World Bank, Lifetime risk of maternal death, http://data.worldbank.org/indicator/SH.MMR.RISK.

ALYNE'S STORY

In 2002, Alyne da Silva Pimentel, a poor, 28-year-old woman of Afro-Brazilian descent, was six months pregnant when she initially sought care at a hospital just outside Rio de Janeiro for severe nausea and abdominal pain. Instead of admitting Alyne, the attending physician insisted that she was fine and sent her home. Two days later, Alyne returned to the hospital complaining of vomiting and feeling extremely ill. At that point, doctors were unable to detect a fetal heartbeat and induced delivery, producing a stillborn fetus. Nonetheless, Alyne's health continued to deteriorate, and 14 hours passed before surgery was performed to remove the placenta, even though this should have occurred immediately. It soon became clear that Alyne needed to be transferred to a higher-tier health facility, yet she was forced to wait more than eight hours before the transfer occurred. During this time, she manifested clinical symptoms of a coma. Upon arriving at the hospital, Alyne was hypothermic and her blood pressure dropped to zero, requiring her to be resuscitated. Nonetheless, the hospital was unable to provide her with an available bed, and left her in an emergency room hallway, where she ultimately died.[75]

Alyne's mother sought justice for her daughter's death in the Brazilian judicial system, but her case languished in court for years. In 2007, the Center for Reproductive Rights and Advocacia Cidada pelos Direitos Humanos submitted an international claim before the CEDAW Committee, seeking accountability for the state's failure to provide Alyne with adequate medical care. The CEDAW Committee issued its decision in 2012 – the first-ever maternal death case decided by an international human rights body. The CEDAW Committee found that the state had violated Alyne's rights to health, non-discrimination and access to justice. The CEDAW Committee indicated that Brazil's maternal health services failed to meet women's distinct health needs and interests. In finding that Alyne faced multiple forms of discrimination, the CEDAW Committee underscored Brazil's failure to address Alyne's "status as a woman of African descent and her socioeconomic background."[76] Specifically, the Committee noted how "discrimination against women based on sex and gender is inextricably linked to other factors that affect women," such as race, health status, class or gender identity.[77] The CEDAW Committee also made clear that when states outsource health services to private institutions, states maintain their due diligence obligation to regulate and monitor the institutions to ensure that the health services are appropriate.[78] The Committee ordered Brazil to provide Alyne's mother and daughter with monetary and symbolic reparations and to take measures of non-repetition to guarantee all women the right to safe pregnancy and childbirth.

The Center for Reproductive Rights is currently working with partner organizations in Brazil to implement the CEDAW Committee's findings. In March 2014, the Brazilian government provided Alyne's mother with monetary reparations and issued a symbolic reparation, naming a maternity ward after Alyne. Follow up work is continuing to ensure that Alyne's daughter receives monetary reparations and that the Brazilian government takes adequate measures to guarantee all women quality maternal health care.

UN Photo/Christopher Herwig

Kou Pealea with her grandchildren in Tonglewin Village, Liberia. Kou Pealea worked as a midwife until her clinic burned down. She now delivers babies in her home.

INTERSECTIONAL DISCRIMINATION AND MATERNAL MORTALITY

In guaranteeing women the right to non-discriminatory access to maternal health care, states must recognize the different experiences faced by different groups of women. Intersectional discrimination occurs where individuals face discrimination based on multiple grounds. For example, a migrant woman may face discrimination both based on her status as a woman and due to her legal status in the host country.

Intersectional discrimination can hinder women's access to reproductive health services, which is particularly detrimental due to their unique reproductive health needs. For instance, women from indigenous communities may be discouraged or prevented from accessing maternal health services due to geographic inaccessibility, degrading or culturally insensitive treatment, or language barriers.[79] States must take targeted measures to ensure that certain groups do not face higher levels of maternal mortality and morbidity as a result of intersectional discrimination. These measures include involving marginalized groups in the design and implementation of maternal health policies and collecting disaggregated information on maternal health outcomes.

DISPARITIES IN MATERNAL MORTALITY RATIOS WITHIN COUNTRIES

All rates are per 100,000 live births

UNITED STATES

AUSTRALIA

NETHERLANDS

Despite the substantial progress many states have made in guaranteeing women the right to safe pregnancy and childbirth, wide disparities still exist in the realization of this right. In many states that have either significantly reduced or have achieved moderate or low overall maternal mortality rates, the effects of these accomplishments are primarily felt among the most privileged members of the population. Meanwhile, populations that have historically been marginalized commonly experience significantly higher maternal mortality rates. For this reason, it is critical that future development agendas address maternal mortality in all countries and across different sectors of society. *For more information, see Section V on page 20.*

**Source are included at the end of the endnotes.*

IV. MATERNAL MORTALITY AND MORBIDITY IN THE HUMAN RIGHTS COUNCIL

In 2006, the Special Rapporteur on the Right to Health, Paul Hunt, issued a groundbreaking report on maternal mortality as a violation of the right to health.[80] This report increased recognition of maternal mortality as a human rights issue in the political arenas of the United Nations (UN). Recognizing the increased traction that maternal mortality was gaining, advocates realized that the issue was ripe for positioning within a UN political body. A civil society coalition formed to support the development of a resolution on maternal mortality and morbidity within the Human Rights Council (HRC), an inter-governmental body within the UN that is charged with monitoring and addressing specific human rights violations and broader thematic issues.[81]

In 2009, as the result of strong leadership on the part of several states and extremely effective organizing on the part of civil society, led by the International Initiative on Maternal Mortality and Human Rights,[82] the HRC adopted a resolution requesting that the Office of the United Nations High Commissioner for Human Rights (OHCHR) prepare a thematic study on preventable maternal mortality.[83] The resulting thematic report provided a valuable overview of the linkages between preventable maternal mortality and morbidity and human rights, including in the areas of equality and non-discrimination, as well as the rights to life, health, education and information.[84] It also called for leadership within the UN system to operationalize a human rights-based approach to maternal morbidity and mortality.[85] Since then, a core group of states, led by Colombia, Burkina Faso, and New Zealand and supported by a diverse group of civil society organizations, has rallied support among HRC members for the continuous recognition of maternal mortality and morbidity as human rights violations through a series of resolutions urging states to take measures to prevent maternal mortality and morbidity.

The HRC passed a follow-up resolution in 2010 to the initial resolution, requesting that OHCHR produce a study on good or effective practices in applying a human rights-based approach to eliminating preventable maternal mortality and morbidity.[86] In the resulting report, OHCHR identified five common features of such an approach:

- incorporating broad social and legal changes to enhance women's status by promoting gender equality and eliminating harmful practices;
- increasing access to contraception and family planning, supported by access to sexuality education;
- strengthening of health systems to improve access to and use of skilled birth attendants and emergency obstetric care;
- addressing the problem of unsafe abortion; and
- improving monitoring and evaluation of states' obligations.[87]

In 2011, the HRC adopted a resolution calling on OHCHR to devise a technical guidance on the application of a human rights-based approach to reducing preventable maternal mortality and morbidity.[88] The resulting publication, *Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity* (Technical Guidance), is groundbreaking in that it reflects the HRC's readiness to move beyond a human rights-based analysis to the **concrete steps** required for states to effectively implement a human rights-based approach to elimination of preventable maternal mortality and morbidity.[89] In 2012, the HRC passed a resolution affirming the Technical Guidance, and requesting monitoring and reporting on how it is being implemented by states and other actors.[90] A HRC resolution is being prepared for 2014, which asks states to report on their use of the Technical Guidance, and periodic resolutions will likely continue in the coming years to call on states to move forward in implementing their human rights obligations related to safe pregnancy and childbirth and to report on the progress they have made.

INTERNATIONAL INITIATIVE ON MATERNAL MORTALITY AND HUMAN RIGHTS

Launched in 2007, the International Initiative on Maternal Mortality and Human Rights (IIMMHR) is a civil society platform, bringing together a diverse group of international, regional and national-level organizations from various disciplines, including human rights and public health, dedicated to promoting the understanding that preventable maternal mortality is a fundamental human rights violation. Working closely with UN actors, including OHCHR, IIMMHR has worked towards substantially increasing accountability for states in fulfilling their duties to eradicate preventable maternal mortality. To this end, IIMMHR played a key role in coordinating civil society support for the first HRC resolution on maternal mortality in 2009 and has supported the subsequent resolutions. Furthermore, IIMMHR greatly supported the development of the Technical Guidance and is launching country-level initiatives on its implementation. Through these initiatives, IIMMHR will identify the challenges and benefits to using the Technical Guidance to promote a human rights-based approach to maternal health care. Furthermore, IIMMHR recently created a *Framework on Human Rights Based Approaches for Preventing Maternal Mortality*, which concretely applies key human rights principles to the prevention of maternal death by detailing various human rights-based approaches to safe pregnancy and childbirth and providing recommendations for their implementation.[91]

In addition to its work surrounding the development and implementation of the Technical Guidance, IIMMHR has conducted field projects in India, Kenya and Peru on quality of maternal health services, access to maternal health care, and capacity-building and awareness-raising on maternal health services as a human right, respectively. It has further devised tools for civil society members to conduct budget analyses in order to hold governments accountable for their commitments to reduce maternal mortality.[92] SAHAYOG, based in India, is the current Secretariat of IIMMHR. From 2007-2011, the Secretariat was based at the Center for Reproductive Rights.

UN Photo/Mark Garten

TECHNICAL GUIDANCE ON MATERNAL MORTALITY AND MORBIDITY

OHCHR's *Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity* provides policymakers with the requisite tools to craft and implement laws, policies and programs to address maternal mortality and morbidity in line with their international human rights obligations. Key elements of the Technical Guidance include:

Enabling Women to Exercise their Human Rights

- States should address the social determinants of health, which effect women's enjoyment of their human rights, including power dynamics, poverty and income inequality, gender discrimination and marginalization of certain groups.[93] To this end, states must take all appropriate measures to eliminate discrimination against women and take targeted measures to realize the rights of marginalized groups.[94] This includes building a just and effective health system that enables *all* women to exercise their right to health, irrespective of their socioeconomic status, race, ethnicity, or other characteristic.[95]

- Women must be enabled to meaningfully participate in all decisions affecting their health, including policy design and budget allocation, identification of problems and evaluation of program/policy implementation.[96]

Enhancing Accountability

- States should use quantitative and qualitative indicators that extend beyond the health sector to collect disaggregated data on structural changes, policy and budgetary efforts and track the concrete results of such measures.[97]

- States should put in place multiple forms of review and oversight of the realization of the right to safe pregnancy and childbirth that include numerous actors at various levels. This includes mechanisms for ensuring accountability for health facilities, ministries of health, private actors, and donors, among others, through processes such as engagement of civil society, legislative oversight, judicial and non-judicial legal mechanisms, and international human rights mechanisms.[98]

- States should expressly enshrine the right to health into law and create accountability mechanisms that enable individuals to assert this right.[99] Where rights are violated, remedies such as restitution, compensation, satisfaction and guarantees of non-repetition must be accessible, affordable, timely and effective. Judicial remedies are critical for violations of sexual and reproductive rights, as they can ensure implementation of laws and policies and compel legal reform where protections are inadequate.[100]

International Assistance and Cooperation

- Development partners should utilize rights-based approaches that protect women's sexual and reproductive health and rights, including by strengthening national health systems and exercising due diligence in overseeing private actors under their control. Development partners should refrain from restricting the use of aid in ways that undermine the realization of women's sexual and reproductive rights.[101]

V. MILLENNIUM DEVELOPMENT GOAL 5: MATERNAL MORTALITY AND MORBIDITY AS A DEVELOPMENT IMPERATIVE

In 2000, when the international community came together and adopted the Millennium Development Goals (MDGs), developing states committed to improve maternal health by reducing their maternal mortality rates by three-quarters between 1990 and 2015. This demonstrated a clear shift from previous efforts which had only addressed maternal health insofar as it impacted child health, solidifying the understanding that enabling women to experience pregnancy and childbirth safely is important in its own right.[102] Furthermore, advocates in this process successfully argued that maternal health care cannot be addressed in a vacuum separate from reproductive health more broadly and in 2005 the narrow focus of MDG5 was expanded to include achieving universal access to reproductive health.[103]

To date, there has been some success in meeting the MDG target on reducing maternal mortality, but the pace of progress has been faltering and MDG5 lags the furthest behind of all the MDGs.[104] In 2013, only 26 countries had met the maternal mortality reduction target or made sufficient progress to do so by the 2015 deadline.[105] South Asia is the only region on track to reach the 2015 target.[106] Furthermore, the way that progress is measured under MDG5 masks disparities in maternal health care among different sectors of states' populations. One of the indicators used to measure progress on MDG5 is the proportion of births that are attended by skilled health personnel. Brazil is a country that is classified as having achieved success on this indicator.[107] However, the high overall coverage for skilled attendance is not enjoyed equally by all Brazilian women. A 2007 study showed that low-income Brazilian women were greater than twenty times more likely not to be attended by skilled personnel during delivery than rich women.[108] Finally, the exclusion of developed states from the MDGs meant that inequalities in access to reproductive health services in those countries were not addressed. For example, although the United States (US) is not included in the MDGs, sectors of the country experience extraordinarily high maternal mortality rates. For example, one county in the state of Mississippi was found to have a maternal mortality ratio of 595 per 100,000 births for women of color, which is substantially higher than the US average of 28 per 100,000 births and is even higher than the rates of many low-income countries in Sub-Saharan Africa.[109]

It is critical that the future development agenda adopts a more holistic view on eradicating maternal mortality and morbidity. The eradication of preventable maternal mortality and morbidity must be squarely rooted within the context of guaranteeing women access to the full range of comprehensive reproductive health information and services, including comprehensive sexuality education, contraception, safe abortion and post-abortion care. Furthermore, the provision of maternal health care cannot just be understood from a medical standpoint. States must take measures to realize women's human rights and promote gender equality in order to ensure that women receive adequate information and have access to and control over the resources to enable them to receive quality maternal health care.

COUNTRY PROGRESS IN REACHING MDG 5

9 COUNTRIES
ON TRACK

40 COUNTRIES
MAKING PROGRESS

16 COUNTRIES
INSUFFICIENT PROGRESS

9 COUNTRIES
NO PROGRESS

"On track" countries have, on average, reduced their maternal mortality ratio from 1990–2010 by 5.5% or more annually. This includes Bangladesh, Cambodia, China, Egypt, Equatorial Guinea, Eritrea, Laos, Nepal and Vietnam.

Countries "making progress" have, on average, reduced their maternal mortality ratio from 1990–2010 by between 2% and 5.5% annually. This includes Afghanistan, Angola, Benin, Bolivia, Brazil, Burkina Faso, Comoros, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea, Haiti, India, Indonesia, Liberia, Madagascar, Malawi, Mali, Mauritania, Mexico, Morocco, Mozambique, Myanmar, Niger, Nigeria, Pakistan, Papua New Guinea, Peru, Philippines, Rwanda, São Tomé and Príncipe, Senegal, Solomon Islands, Tanzania, Togo, Uganda, Uzbekistan and Yemen.

Countries making "insufficient progress" have, on average, reduced their maternal mortality ratio from 1990–2010 by less than 2%. This includes Azerbaijan, Burundi, Central African Republic, Djibouti, Gabon, Guatemala, Guinea-Bissau, Iraq, Kenya, Democratic People's Republic of Korea, Kyrgyzstan, Sierra Leone, Sudan, Tajikistan, Turkmenistan and Zambia

Countries that have made "no progress" have had increased maternal mortality ratios from 1990-2010. This includes Botswana, Cameroon, Chad, Congo, Lesotho, Somalia, South Africa, Swaziland and Zimbabwe.

Source: Unicef, Countdown to 215: Building a Future for Women and Children 14-15 (2012).

VI. REGIONAL EFFORTS TO IMPROVE MATERNAL HEALTH

In addition to increased attention to maternal morbidity and mortality within the UN system, regional bodies across the globe have also contributed to the establishment of safe pregnancy and childbirth as a human right and provided fora for states to participate in political declarations committing to making this right a reality for all women. These efforts have reinforced those taking place at the UN, demonstrating that this issue affects women across the globe.

Africa

The African Union has addressed the importance of safe pregnancy and childbirth through both its political and human rights mechanisms. While the African Charter on Human and Peoples' Rights protects a range of human rights related to safe pregnancy and childbirth,[110] the entry into force of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) in 2005 greatly supplemented these protections. The Maputo Protocol explicitly protects women's right to health, including their sexual and reproductive health,[111] and requires states to take all appropriate measures to "provide adequate, affordable and accessible health services, including information, education, and communication programmes to women, especially those in rural areas."[112]

Furthermore, in 2008, the African Commission on Human and People's Rights, which is responsible for interpreting the African Charter on Human and People's Rights, issued a resolution on maternal mortality in Africa, expressly recognizing that "preventable maternal mortality in Africa is a violation of women's rights to life, dignity and equality enshrined in the African Charter."[113] The resolution was accompanied by recommendations detailing ways in which state parties to the Charter can individually and collectively address the problem of maternal mortality, such as through budgetary prioritization of the health sector to ensuring maternal health care facilities have adequate staffing and equipment.[114] Finally, the Conference of African Ministers of Health, which is part of the African Union, adopted the Maputo Plan of Action in 2006, which is designed to improve sexual and reproductive health, including by reducing maternal deaths throughout Africa.[115]

Asia

Although Asia does not have a regional human rights system, a number of regional political commitments on addressing maternal mortality have been adopted by countries throughout Asia. The Association of Southeast Asian Nations' Strategic Framework on Health and Development (2010-2015) reflects countries in the region's shared commitment to promote access to health care, including in the areas of maternal and child health.[116] In 2013, members of the UN Economic and Social Commission for Asia and the Pacific adopted the Asian and Pacific Ministerial Declaration on Population and Development, which sets forth the region's population and development agenda. In this declaration, states agreed to prioritize the elimination of preventable maternal mortality,[117] by providing comprehensive maternity care, including pre- and post-natal care and safe delivery services;[118] improving the use of skilled birth attendants, management of complications from unsafe abortion, and training health providers;[119] and improving nutrition.[120]

Europe

The Council of Europe, a regional intergovernmental human rights institution, has addressed the importance of reducing maternal mortality and morbidity through both the European Committee of Social Rights and the Parliamentary Assembly of the Council of Europe (PACE). The European Committee of Social Rights, which monitors implementation of the European Social Charter, has held states accountable for their failure to take adequate measures to enable women to safely experience pregnancy. For example, the status of maternal health in Russia was recently found to be in violation of Article 11 of the European Social Charter "on the ground that insufficient efforts have been undertaken to reduce the high infant and mortality rates."[121] Additionally, PACE, a regional political body consisting of parliamentarians from Council of Europe member states, has issued recommendations and resolutions on maternal mortality and morbidity. In Recommendation 1903 from 2010, PACE called on states to address maternal mortality and morbidity by reducing unsafe abortion, ensuring universal access to comprehensive sexual and reproductive health services, and addressing the needs of vulnerable populations.[122] More recently, the Parliamentary Assembly unanimously adopted Resolution 1975, on global inequalities and the MDGs, encouraging states to "promote the guarantee of sexual and reproductive health and rights for women and girls, in particular with a view to avoiding unwanted pregnancies and further reducing maternal mortality."[123]

Latin America and the Caribbean

Within Latin America and the Caribbean, the Inter-American human rights system has drawn increased attention to the human rights violations stemming from preventable maternal mortality and morbidity. In a 2010 report entitled *Access to Maternal Health Services from a Human Rights Perspective*, the Inter-American Commission on Human Rights framed high rates of maternal mortality and morbidity as human rights violation, highlighted the disproportionate impact that maternal death has on marginalized populations, and detailed states' obligations to respect, protect and fulfill the right to maternal health services.[124] In 2010, in the case of *Xákmok Kásek Indigenous Community v. Paraguay*, the Inter-American Court of Human Rights issued a landmark ruling, finding a violation of the right to life for the preventable maternal death of a 38-year old woman who died following complications during labor for which she received no medical attention.[125] Concluding that Paraguay failed to take positive measures that reasonably could have been expected to prevent or avoid the risk to life,[126] the Court found that "states must design appropriate health-care policies that permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate pre-natal and post-partum care, and legal and administrative instruments for healthcare policies that permit cases of maternal mortality to be documented adequately."[127]

Furthermore, in 2013, a high-level conference was convened by the government of Panama and several international agencies to mobilize support for reducing disparities in reproductive, maternal and child health care.[128] As a result, 27 governments from throughout Latin America and the Caribbean and various international partners, including civil society organizations and intergovernmental agencies, signed the Declaration of Panama, committing to reduce health inequities, particularly in the areas of maternal and reproductive health.[129] The Declaration outlined five major pillars for achieving this goal, including the provision of universal health coverage, the mobilization of political leadership, and the promotion of regional and strategic alliances.[130] With aims that are closely tied to the MDGs, the Declaration galvanized renewed support for the importance of addressing preventable maternal deaths as well as broader socio-economic and ethnic inequalities in health outcomes.[131]

Presidencia Perú

VII. SUCCESSES IN REDUCING MATERNAL MORTALITY AND MORBIDITY AT THE NATIONAL LEVEL

A number of states have taken significant steps towards realizing their international and regional commitments to address preventable maternal mortality and morbidity. These achievements provide important leadership and can support other states in their efforts to ensure all women the right to safe pregnancy and childbirth.

Eritrea

Eritrea is one of the few countries that has achieved MDG 5 by reducing its maternal mortality rate from 1700 to 380 deaths per 100,000 live births during the last several decades.[132] As a geographically small country with significant constraints on health personnel capacity,[133] centralization of obstetric services allowed Eritrea to maximize safety, safely store important equipment and blood products, and offer structured contraceptive counseling.[134] The country also serves as a valuable example of a low-resource setting where cooperation between the government and NGOs has produced significant positive change in maternal health outcomes.[135] The government of Eritrea established a task force in 2010 to implement the Campaign on Accelerated Reduction of Maternal Mortality in Eritrea and is working diligently to address deficits in personnel and capacity in the context of maternal health care, including by training physicians on the provision of comprehensive obstetric and neonatal care.[136] Lastly, Eritrea has established Maternity Waiting Homes, which are temporary shelters for pregnant women located near a health facility that have particularly enabled women in remote coastal regions to have skilled care attendance during delivery.[137]

Nepal

Between 1990 and 2013, Nepal succeeded in reducing its maternal mortality rate by 76%.[138] This dramatic reduction is linked to the country's "reframing basic health needs as health rights."[139] In 2007, Nepal adopted an interim constitution which guarantees Nepalese women the "right to reproductive health and other reproductive rights."[140] The country's National Safe Motherhood and Newborn Health – Long Term Plan (2006-2017) contains a number of provisions that explicitly link the country's approach to maternal health with core human rights, including measures to increase accountability for maternal health, build women's capacity to assert their rights, and address resource and power disparities that perpetuate inequalities.[141] Nepal has pursued a number of strategies related to expansion of maternal health services, including ensuring access to medical abortion, improving management of post-partum hemorrhage, providing human resources for safe delivery, and improving transportation to health facilities in remote areas.[142] The availability of comprehensive obstetric services has been greatly expanded[143] and in 2009, Nepal launched a program offering free delivery services and cash incentives for women and providers throughout the country in order to guarantee the constitutional right to free health care, including maternal health services.[144]

Romania

Romania is a celebrated success story of a country that has achieved a substantial decline in maternal death and disability. In 1989, Romania repealed its restrictive abortion law, and in just one year, the maternal mortality rate declined by one half.[145] Maternal mortality has since declined by another 80% between 1990 and 2013.[146] In addition to the reduction of maternal mortalities from unsafe abortion, increased availability of contraceptives also played a significant role in decreasing the number of maternal deaths. In the 1990s, Romania developed a network of family planning clinics and family planning services were incorporated into primary health care. Additionally, modern contraceptives were made freely available to particularly vulnerable population groups, resulting in an overall increase in contraceptive use.[147] In 2001, in cooperation with USAID and the JSI Research and Training Institute, Inc. the government of Romania introduced the Romanian Family Health Initiative, which is based on three core pillars, including increased capacity of health providers, increased awareness of family planning and reproductive health issues and services, including the right to access abortion services, and ensuring affordable access to modern contraception.[148]

Uruguay

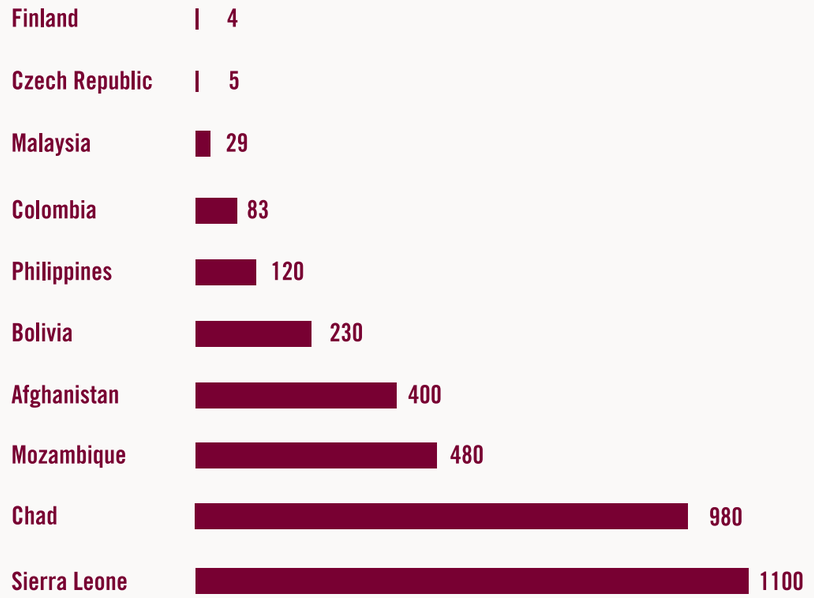
Among Latin American countries, Uruguay has shown impressive progress in reducing maternal mortality and now has one of the lowest rates in the region. Since 1990, maternal mortality in Uruguay has declined by nearly 70%.[149] Unsafe abortion used to be the most common cause of maternal mortality in Uruguay,[150] but in the early 2000s, Uruguay adopted a harm-reduction approach to illegal abortion, with doctors counselling women on abortion methods,[151] which enabled women to safely induce medical abortions and receive follow-up care.[152] Since 2005, the government has focused on the improvement of maternal care during the pre- and post-natal periods, as well as ensuring appropriate contraceptive coverage for adolescents.[153] Furthermore, in 2010, as a result of a successful pilot program, the Uruguayan government issued a decree mandating that all primary health care providers, including those in the private sector, offer comprehensive reproductive and sexual health services.[154] Furthermore, in 2012, Uruguay enacted a law permitting abortion without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds.[155]

DISPARITIES IN MATERNAL MORTALITY RATIOS BETWEEN COUNTRIES

230 100,000 LIVE BIRTHS IN DEVELOPING COUNTRIES

VS.

16 100,000 LIVE BIRTHS IN DEVELOPED COUNTRIES



Sources: The World Bank, Maternal mortality ratio, http://data.worldbank.org/indicator/SH.STA.MMRT. UNFPA, Rich Mother, Poor Mother: The Social Determinants of Maternal Death and Disability (2012), available at http://www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-Poormother.pdf.

VIII. HOLDING STATES ACCOUNTABLE FOR REALIZING THE RIGHT TO SAFE PREGNANCY AND CHILDBIRTH

States' obligations to address and prevent maternal mortality and morbidity are recognized in numerous international and regional human rights instruments, political declarations, and national-level laws and policies. In order to translate these protections and commitments into the eradication of preventable maternal mortality and morbidity, establishing mechanisms to hold states accountable for their obligations to guarantee the right to safe pregnancy and childbirth is crucial. Health and human rights advocates have consistently made clear that a means to assess states' compliance with their human rights obligations in regards to safe pregnancy and childbirth is critical for effectuating meaningful change.[156]

National-level Accountability Strategies

At the state and local levels, advocates have utilized a range of tactics to successfully hold states accountable for their obligation to eliminate preventable maternal mortality and morbidity, including documenting the impact of inadequate maternal health care, engaging with national human rights institutions, and utilizing the judiciary to adjudicate individual human rights violations that are demonstrative of systemic problems.

Documenting the Impact of Inadequate Maternal Health Care

Fact-finding reports that document the human rights violations that result from the lack of quality maternal health services are critical for awareness raising, particularly where states fail to collect accurate and disaggregated information on maternal health outcomes. Beginning with a 2003 fact-finding in Mali with the Association des Juristes Maliennes, the Center for Reproductive Rights and its partners have conducted numerous fact-finding reports on women's experiences in the context of safe pregnancy and childbirth in countries across the globe including, El Salvador, India, Kenya, Nigeria, and the US.[157] Other civil society organizations have also extensively documented violations of the right to safe pregnancy and childbirth, including the Latin American and Caribbean Committee for the Defense of Women's Rights, Human Rights Watch, Amnesty International and Physicians for Human Rights.[158] These reports have documented the manner in which laws, policies and pervasive social norms contribute to maternal mortality and result in human rights violations. Documenting these human rights violations also provides individuals whose human rights have been violated a vehicle to have their voices heard. The information uncovered in such reports can also influence future advocacy strategies and shape the formulation of measures of redress.

Engaging with National Human Rights Institutions

National Human Rights Institutions (NHRIs) provide individuals whose rights have been violated and civil society organizations a non-judicial forum through which they can hold governments accountable for their human rights obligations. Depending on their mandate, NHRIs may be able to launch public inquiries, adjudicate complaints regarding alleged human rights violations, and make legislative or policy recommendations to the state.

In 2011, as a result of a request by the Center for Reproductive Rights and the Federation of Women Lawyers (FIDA) Kenya, the Kenya National Commission on Human Rights commenced a public inquiry into the status of women's sexual and reproductive rights in Kenya. As a result of this public inquiry, the Commission published an extensive report, finding that the state was failing to realize women's sexual and reproductive rights, including in the context of maternal health care. The Commission specifically advised the government to address maternal deaths from a human rights perspective, remove financial barriers to reproductive health services, and establish mechanisms through which women can file complaints against health care facilities for being mistreated.[159]

Using National-Level Litigation to Hold States Accountable

National-level litigation has been one of the most effective tools for ensuring that governments take appropriate measures to realize the right to safe pregnancy and childbirth. Individual petitions have provided judicial actors with the real stories of the tribulations women face during pregnancy and childbirth, shedding light on the serious damage resulting from government inaction. In instances where human rights violations have been found, states have been ordered to take specific, concrete measures to ensure women the right to safe pregnancy and childbirth.

Human rights advocates have filed a series of public interest litigation cases in India challenging the state's failure to realize women's right to safe pregnancy and childbirth. While several of these cases are still pending, Indian courts have handed down favorable decisions in others, demonstrating the utility of public interest litigation in India. Through an initiative spearheaded by the Human Rights Law Network in 2010, the High Court of Delhi held the Indian government responsible for its failure to provide adequate maternal health services in two consolidated cases,[160] one on the denial of maternal health services to a woman who was forced to give birth without assistance under a tree, and the other on a preventable maternal death.[161] The court found violations of the rights to life and health, including the right to maternal health care as enshrined in national and international law,[162] framing the public health system's duty to provide maternal health care to all women as an essential element of the right to health.[163]

Two years later, in the case of *Sandesh Bandal v. Union of India*, the court addressed the acute shortage of trained health care providers, services, and equipment for pregnant women seeking care, finding a violation of the right to life and ordering the state to improve health facility conditions, make improvements to basic infrastructure, ensure around-the-clock availability of emergency vehicles, and provide vaccinations for pregnant women.[164] *Charm v. Bihar*, which is currently pending, alleges violations of the right to cruel, inhuman and degrading treatment, among other rights, as a result of the failure to provide low-income, pregnant women access to quality maternal health services.[165] Further, *Salenta v. Uttar Pradesh*, also currently pending, is the first case in India's high court on maternal morbidity and seeks accountability for poor quality of services and lack of oversight within the health system.[166]

Maternal Death Audits

Maternal death reviews, which are community and/or facility based, systematically examine the incidence and prevalence of maternal mortality and morbidity, thereby enabling health professionals to review the treatment

World Bank/Simone D. McCourtie

provided and identify ineffective medical practices.[167] Community-based maternal death reviews can establish the cause of death and illuminate any personal, familial and/or community factors contributing to the death. Generally, in such reviews trained field-workers interview family members and others who can help to identify factors leading to the death[168] which in turn facilitates the introduction of measures to prevent maternal deaths and disability.[169] Facility-based reviews are "qualitative, in-depth investigations of the causes of, and circumstances surrounding, maternal deaths which occur in healthcare facilities."[170]

As the result of a joint collaboration between Columbia University and UNICEF, Sri Lanka has conducted annual maternal death reviews to identify the causes of every maternal death, including whether there were contributory factors, such as delays in seeking or accessing care.[171] Compared to civil registration systems, where health care providers input cause of death and which are commonly subject to under-reporting of maternal deaths, these audits have provided substantially more accurate information on the factors leading to maternal mortalities, which has enabled policymakers to more effectively address the causes of maternal mortality.[172]

Human Rights Impact Assessments

Human rights impact assessments allow policymakers to consider the potential impacts of policies both before and throughout their implementation to ensure they adhere to human rights standards and do not inadvertently have harmful effects. In 2014, the World Health Organization published a tool to assist states in evaluating their laws, policies and programs on sexual and reproductive health to ensure their compliance with international human rights standards.[173] This module assists countries in identifying and understanding their human rights obligations; creating participatory, multi-stakeholder processes for assessing realization of the rights to sexual and reproductive health; and devising action plans to implement the recommendations.[174]

Citizen Monitoring of Maternal Health Care

Citizen monitoring is a process wherein individuals assess whether state actors are complying with their obligations to ensure the right to safe pregnancy and childbirth.[175] By identifying lapses in the provision of maternal health services, these assessments can be used to hold state actors accountable for the human rights obligations and other commitments made to their respective populations. In 2008, IIMMHR and CARE Peru launched "No Woman Left Behind," an initiative to strengthen local civil society groups' knowledge of and capacity to hold the state accountable for its human rights obligations through trainings on the right to safe pregnancy and childbirth and citizen surveillance of health services.[176] As a result, civil society organizations undertook citizen monitoring of health services and were able to utilize these findings to advocate for improved services. Furthermore, this initiative enabled civil society organizations to engage with local and regional state actors charged with realizing the right to health.[177]

Health Councils/Tribunals

Health councils, patient's rights tribunals and healthcare commissions are autonomous, quasi-judicial accountability bodies, which are generally established pursuant to legislation and can incorporate civil society input in policy creation and implementation.[178] Health Councils may function as independent, democratically-elected bodies with the authority to approve health plan budgets and/or act as a complaint mechanism.[179] Patient's Rights Tribunals or Healthcare Commissions handle complaints about the healthcare system, services or employees.[180] These quasi-judicial mechanisms may also issue binding resolutions that compel changes within the health sector, conduct investigations into particular facets of the health system and formulate recommendations for implementation by policymakers.[181] In the United Kingdom, following a national review of maternity services conducted by the Healthcare Commission, which revealed troubling variations in the quality

of care throughout the country, in 2008, the Healthcare Commission collaborated with stakeholders, such as women and clinicians, to establish performance benchmarks for providing maternity services.[182]

Holding States Accountable at the UN: Treaty Monitoring Bodies and the Universal Periodic Review

In addition to the domestic mechanisms to hold states accountable for their international human rights obligations, advocates have also used legal and political processes within the UN. While TMBs provide an arbiter that determines whether states are abiding by their human rights obligations, the Universal Periodic Review enables states to issue recommendations to other states concerning their progress in realizing human rights. In addition to the direct outcomes of these processes, both mechanisms allow advocates to shed light on the human rights violations taking place within a country's' borders before an international audience, which may also persuade states to take action to improve the human rights situation.

Treaty Monitoring Bodies

The TMB reporting process provides civil society organizations with an opportunity to highlight where states are falling short of their human rights obligations through the shadow reporting process. Shadow reports are produced by civil society organizations to provide TMBs with independent information on the steps that states are taking – or failing to take – to realize their human rights obligations. As a result of the dialogue created through this process, TMBs issue concluding observations to states, advising them of the measures they must take to comply with their international human rights obligations. For example, as the result of a shadow report that the Center for Reproductive Rights submitted to the CEDAW Committee concerning Pakistan's high rates of maternal mortality and morbidity,[183] the CEDAW Committee took Pakistan to task, urging the state to strengthen its efforts to reduce maternal mortality and morbidity, improve women's access to health care facilities, and guarantee access to contraception.[184]

Furthermore, where states have adopted Optional Protocols to international human rights treaties that authorize TMBs to adjudicate individual petitions, redress can be sought for specific instances of human rights violations. In the aforementioned case of *Alyne v. Brazil*, the CEDAW Committee ordered Brazil to both provide compensation to Alyne's mother and daughter, and to take measures of non-repetition to ensure that similar human rights violations do not occur in the future.

Universal Periodic Review

The Universal Periodic Review (UPR) is a HRC mechanism enabling states to report on the measures they have taken to improve their domestic human rights situations[185] and to receive participatory feedback, questions and recommendations from other states. The state under review then decides whether it will accept or reject the recommendations issued. Civil society stakeholders can influence the UPR process by submitting written statements to OHCHR, which prepares a report summarizing information from civil society for each state, delivering an oral intervention during the review, and by lobbying states to make recommendations to the state under review on specific human rights issues. For example, in 2012, Zambia accepted a number of recommendations on maternal health care which were initially raised in the Center for Reproductive Rights' submission to OHCHR. These included the recommendations that Zambia allocate specific funding for maternal health care, strengthen its efforts to reduce maternal mortality rates, and ensure free access to health facilities for those in need.[186] The UPR also offers a valuable forum to advance implementation of OHCHR's Technical Guidance,[187] as the Technical Guidance can serve as a benchmark for measuring the extent to which states are adopting a human rights-based approach to maternal mortality and morbidity.

IX. RECOMMENDATIONS FOR REALIZING THE RIGHT TO SAFE PREGNANCY AND CHILDBIRTH

While states have made advances in realizing the right to safe pregnancy and childbirth for women across the globe, there is still much to be done. The following recommendations provide concrete guidance for actors at the national, regional and global levels:

Government Actors at the National Level

- Promptly implement a human rights-based approach for preventing maternal mortality and morbidity in accordance with the OHCHR's Technical Guidance. To this end, states should devise a national plan on the laws, policies and programs that must be amended or put into place in order to adopt a human rights-based approach to safe pregnancy and childbirth.

- Take targeted measures to guarantee women substantive equality in order to enable them to exercise their human rights and seek redress where their rights are violated. Such measures should include addressing gender roles, stereotypes and power dynamics that undermine the realization of women's human rights, as well as taking measures to address the social and other determinants of health. States should take positive measures to ensure all women access to the full range of sexual and reproductive health care and information, including maternal health care, contraception and safe abortion services. Such efforts should include targeted measures to ensure women from marginalized groups access to such services and address disparities in access to and quality of comprehensive reproductive health care.

- Guarantee women, particularly marginalized groups of women, meaningful participation in the development and implementation of all laws, policies and programs affecting their health, including those designed to address maternal mortality and morbidity. Women must also be included in monitoring and evaluating such programs.

- Guarantee accountability and redress.

  - Enshrine the rights to life, health and gender equality into law and ensure that these rights are both enforceable and justiciable. To this end, individuals and civil society organizations must have the ability to challenge lack of or inadequate implementation of laws, policies, and programs to guarantee women's right to safe pregnancy and childbirth.

  - Ensure that meaningful and effective administrative and judicial remedies are in place and that they are accessible, affordable, and available to women. To this end, states should take measures to guarantee women access to the necessary information and resources to seek redress for violations of their right to safe pregnancy and childbirth, including by ensuring appropriate mechanisms are in place for women to file complaints against individuals and institutions, strengthening national human rights institutions, providing free legal assistance as needed to women whose rights are violated.

For Regional and UN Human Rights Bodies

- Continue holding states accountable for their failure to guarantee women the right to safe pregnancy and childbirth. To this end, human rights bodies should ensure states' compliance with their immediate obligation to ensure women's right to safe motherhood and maternal health care; examine whether overall maternal mortality rates mask disparities in access to or quality of maternal health services; and provide states with strong recommendations on the targeted, concrete measures they must take to realize women's human rights.

- Continue to recognize states' failure to ensure safe pregnancy and childbirth as violations of the rights to rights to life, health, equality and nondiscrimination and freedom from cruel, inhuman and degrading treatment.

For Intergovernmental Bodies

- Ensure that future development agendas adopt a holistic approach to the eradication of preventable maternal mortality and morbidity, squarely rooting it within the social context where such deaths occur and recognizing the importance of guaranteeing gender equality and that women have access to comprehensive sexual and reproductive health services.

- Strengthen the use of intergovernmental accountability mechanisms, such as the UPR, to hold states accountable for their duties to address maternal mortality and morbidity. To this end, states should more routinely inquire and make recommendations about the status of maternal health care. States under review should commit to take concrete measures to address elevated or disparate rates of maternal mortality and morbidity.

UN Photo/Hien Macline

TIMELINE

1994

The International Conference on Population and Development's Programme of Action recognizes women's right to safe pregnancy and childbirth

2000

The Millennium Development Goals are adopted, with states committing to reduce by three-quarters their maternal mortality rates between 1990 and 2015

Center for Reproductive Rights convened the first expert group to discuss safe pregnancy as a human rights issue and to develop strategies to tackle maternal mortality and ensure human rights-based accountability

2001

The case of *Xákmok Kásek Indigenous Community v. Paraguay* was filed before the Inter-American Commission on Human Rights

2003

Center for Reproductive Rights, in conjunction with the Association des Juristes Maliennes, conducts its first fact-finding on the right to safe pregnancy and childbirth, exploring access to maternal health services for women in Mali

2005

Target 5B, on universal access to reproductive health, is added to Millennium Development Goal 5

The Maputo Protocol enters into force, providing protection within the African human rights system for women's maternal health

2006

UN Special Rapporteur on the Right to Health, Paul Hunt, issues landmark report classifying maternal mortality as a right to health issue

The Maputo Plan of Action is adopted by the Conference of African Ministers of Health, a framework designed to improve sexual and reproductive health, including by reducing maternal deaths throughout Africa

2007

The International Initiative on Maternal Mortality and Human Rights is launched

2008

African Commission adopts Resolution 135 on preventing maternal mortality in Africa

Center for Reproductive Rights and Advocacia Cidada pelos Direitos Humanos files *Alyne v. Brazil* before the Committee on the Elimination of Discrimination against Women

The International Initiative on Maternal Mortality and Human Rights and CARE Peru launch "No Woman Left Behind" initiative

2009

The Human Rights Council adopts its first resolution on maternal mortality and morbidity, requesting that the Office of the High Commissioner of Human Rights prepare a thematic study on preventable maternal mortality

The Human Rights Law Network in India files *Salenta v. Uttar Pradesh*

2010

Inter-American Commission on Human Rights recognizes an individual maternal death as human rights violation in case of *Xákmok Kásek Indigenous Community v. Paraguay*

The Human Rights Council adopts its second maternal mortality resolution, requesting that the Office of the High Commissioner of Human Rights produce a study on good or effective practices in applying a human rights-based approach to eliminating preventable maternal mortality and morbidity

The Parliamentary Assembly of the Council of Europe adopts Recommendation 1903, calling on states to address maternal mortality and morbidity by reducing unsafe abortion, ensuring universal access to comprehensive sexual and reproductive health services, and addressing the needs of vulnerable populations

The High Court of Delhi holds the Indian government responsible for its failure to provide adequate maternal health services in two consolidated cases, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Jaitun v. Maternal Hospital MCD*

2011

Committee on the Elimination of Discrimination against Women issues its decision in *Alyne v. Brazil*, finding the state responsible for a range of human rights violations in the first maternal mortality case decided by an international human rights body

2011 (continued)

The Human Rights Council adopts a resolution calling on the Office of the High Commissioner of Human Rights to devise a technical guidance on the application of a human rights-based approach to reducing preventable maternal mortality and morbidity

Human Rights Law Network in India files *Charm v. Bihar*

2012

The Office of the High Commissioner of Human Rights issues the Technical Guidance on Maternal Mortality and Morbidity, and the Human Rights Council adopts a resolution affirming the Technical Guidance and requesting monitoring and reporting on its implementation

The case of *Sandesh Bandal v. Union of India* is decided, finding a violation of the right to life and ordering the state to improve health facility conditions, make improvements to basic infrastructure, ensure around-the-clock availability of emergency vehicles, and provide vaccinations for pregnant women

The Kenya National Commission on Human Rights issues its findings from the public inquiry into the status of women's sexual and reproductive rights in Kenya, calling on the government to take a range of measures related to maternal health care

2013

Declaration of Panama is adopted by 27 governments from throughout Latin America and the Caribbean, affirming their commitment to reducing inequities in health care, including by addressing maternal mortality

The UN Economic and Social Commission for Asia and the Pacific adopts the Asian and Pacific Ministerial Declaration on Population and Development, prioritizing the elimination of maternal mortality

2014

The Brazilian government provides the monetary reparations to Alyne's mother and symbolic reparations ordered by the Committee on the Elimination of Discrimination against Women in *Alyne v. Brazil*

The Parliamentary Assembly of the Council of Europe adopts Resolution 1975, on global inequalities and the MDGs, encouraging states to further reduce maternal mortality and morbidity

Human Rights Council considers a resolution calling on states to further implement the technical guidance on the application of a human rights-based approach to reducing preventable maternal mortality and morbidity

Endnotes

1 Alyne da Silva Pimentel Teixeira v Brazil, Committee on the Elimination of Discrimination against Women (CEDAW Committee), Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011); Committee Against Torture (CAT Committee), *Concluding Observations: Paraguay,* para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); *Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).

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4 Tabassum Firoz, et al., *Measuring maternal health: focus on maternal morbidity*, 91 Bull. World Health Organization 794 (2013) [hereinafter *Measuring maternal health: focus on maternal morbidity*].

5 *See* WHO, Maternal Mortality Factsheet No. 348, *supra* note 3.

6 *See* UNFPA, Rich Mother, Poor Mother: The Social Determinants of Maternal Death and Disability (2012), *available at* http://www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-Poormother.pdf.

7 *Id.*, at 1.

8 *See id.*

9 WHO, Reproductive, Maternal, Newborn and Child Health and Human Rights: A Toolbox for Examining Laws, Regulations and Policies 32 (2014), *available at* http://apps.who.int/iris/bitstream/10665/126383/1/9789241507424_eng.pdf?ua=1&ua=1 [hereinafter Reproductive, Maternal, Newborn and Child Health and Human Rights: A Toolbox for Examining Laws, Regulations and Policies (2014)]. References to "women" throughout this publication includes both women and girls.

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11 *Measuring maternal health: focus on maternal morbidity, supra* note 4, at 795.

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13 WHO, Maternal Mortality Factsheet No. 348, *supra* note 3.

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17 *See, e.g.*, Mamady Cham, Johanne Sundby & Siri Vangen, *Maternal mortality in the rural Gambia, a qualitative study on access to emergency obstetric care*, 2 Reprod. Health, 1, 3 (2005).

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[22] Pacagnella et al., *The role of delays in severe maternal morbidity and mortality: expanding the conceptual framework*, *supra* note 14 at 157-158.

[23] *Id.*, at 156.

[24] WHO, What are social determinants of health? (2013), *available at* http://www.who.int/social_determinants/sdh_definition/en/.

[25] UNDP, A Social Determinants Approach to Maternal Health: Roles for Development Actors, 7 (2011), *available at* http://www.undp.org/content/dam/undp/library/Democratic%20Governance/Discussion%20Paper%20MaternalHealth.pdf.

[26] *Id.*

[27] *Id.*, at 19. Enabling girls to stay in school and expanding their economic and employment opportunities elevates the status of women in societies and contributes to reducing power imbalances between men and women. In turn, women are empowered to exercise greater autonomy, including in regards to their reproductive capacities.

[28] *See, e.g.*, Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003); *Mongolia*, para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); *Peru*, para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Trinidad and Tobago*, para. 18, U.N. Doc. CCPR/CO/70/TTO (2000); Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, paras. 7.5-7.6, U.N. Doc. CEDAW/C/49/D/17/2008 (2011); CEDAW Committee, *Concluding Comments: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Brazil,* paras. 28-29, U.N. Doc. E/C.12/BRA/CO/2 (2009); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add. 16 (1997); CAT Committee, *Concluding Observations: Paraguay,* para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); *Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).

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[32] *See, e.g.*, CEDAW Committee, *Concluding Comments: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999) ("[T]he Committee notes 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."); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) ("So as to guarantee the right to life, the State should strengthen its efforts . . . in ensuring the accessibility of health services, including emergency obstetric care."); Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Democratic Republic of Congo*, U.N. Doc. CRC/C/COD/CO/2, para. 33-34 (2009).

[33] *See* Convention on the Elimination of All Formed of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12, paras. 1-2, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc .A/34/46, U.N.T.S. 13 (*entered into force* Sept 13, 1981) [hereinafter CEDAW]; CEDAW Committee, *General Comment No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 365, para. 31(c), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 11) (2008); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3 1976); ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 80-81, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24, para. 2(d), G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (19890 (*entered into force* Sept. 2, 1990); CRC Committee, *General Comment No. 15: On the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, (66th Sess., 2013), paras. 34-35, U.N. Doc. CRC/C/GC/15 (2013); CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 417, para. 27, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); Office of the United Nations High Commissioner for Human Rights (OHCHR), *Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights*, para. 17, U.N. Doc. A/HRC/13/39 (Apr. 16, 2010) [hereinafter *OHCHR Report on preventable maternal mortality and morbidity and human rights*].

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[42] *See, e.g.*, Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).

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[64] *See, e.g.*, CEDAW Committee, *Concluding Observations: Paraguay,* paras. 30-31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).

[65] *See, e.g.*, CRC Committee, *Concluding Observations: Liberia,* paras. 64-65, U.N. Doc. CRC/C/LBR/CO/2-3 (2012).

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[86] Human Rights Council, *Resolution 15/17: Preventable maternal mortality and morbidity and human rights: follow up on Council Resolution 11/8*, (15th Sess., 2010), para. 9, U.N. Doc. A/HRC/RES/15/17. (2010).

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[95] *Id.* para. 16

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[97] *Id.* paras. 69-70.

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[100] *Id.* paras. 76-77.

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CENTER FOR REPRODUCTIVE RIGHTS

120 Wall Street, 14th Floor
New York, New York 10005
Tel. 917 637 3600 **Fax.** 917 637 3666