10

Maternal mortality and women's right to health

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1 Introduction

Every day around 800 women die from preventable causes related to pregnancy and childbirth. Almost all such maternal deaths (99 per cent) take place in developing countries, most often in poor, rural areas. More than half of maternal deaths occur in sub-Saharan Africa, and one-third in South Asia. Complications during and following pregnancy and childbirth, as well as unsafe abortions, are the major causes, accounting for 80 per cent of all maternal deaths. Most maternal deaths are avoidable, as the healthcare solutions to prevent or manage complications are well known. However, in many developing countries women do not have access to adequate healthcare services and skilled care during pregnancy and childbirth. Poor women in remote areas are the least likely to receive adequate help and services. Factors such as poverty, distance, lack of information, inadequate services and cultural practices prevent women from receiving or seeking adequate care during pregnancy and childbirth.[1]

Despite the fact that maternal deaths happen more often than many human rights violations, it is only recently that the international human rights community has given maternal mortality its attention. In this chapter, the high incidence of maternal mortality and the lack of access to adequate healthcare services in many developing countries is conceptualized as a violation of women's rights to life and health, constituting a particular form of gender-based discrimination and structural disadvantage suffered especially by poor women in low-resource settings (see Articles 1 and 2 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)). In order to secure non-discrimination and substantive equality, the distinct female experience and the needs

[1] World Health Organization (WHO), Fact Sheet No. 348, May 2012.

associated with reproduction must be integrated into human rights norms and principles.[2] Substantive equality requires that more attention be paid to the factual situation of women, acknowledging women's disadvantaged position and the need for structural change.[3] As pointed out by scholars of women's human rights, non-discrimination and substantive equality often require legal analysis based on empirical knowledge of women's situations.[4] Reduction of maternal mortality requires accurate and country-specific information concerning the causes of maternal deaths, women's *de jure* and de facto access to reproductive healthcare services (including abortion services) and the reasons why such services are not accessible. In addition, effective strategies of state accountability for violations of women's rights to life and health, as well as targeted implementation and fulfilment of state obligations in this regard, are imperative in order to ensure adequate maternal healthcare services for women on the ground.

2 Maternal mortality: definition and statistics

A maternal death is defined by the World Health Organization (WHO) as the death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.[5] In other words, the death must be linked to obstetric complications related to pregnancy.[6] It is estimated that at least 15 per cent of all pregnant women will develop serious obstetric complications that require life-saving access to quality obstetric services.[7] If left untreated, these complications will lead to death or severe disability. Because such obstetric complications often cannot be

[2] See the chapters by Fredman, van Leeuwen and Holtmaat in this volume.
[3] Banda in this volume (Chapter 2, section 7).
[4] T. S. Dahl, *Kvinnerett I* [*Women´s Law I*] (Oslo: Universitetsforlaget, 1985) at 74; A. Hellum, *Women's Human Rights and Legal Pluralism in Africa* (Oslo: Tano Aschehoug, 1999) and I. Ikdahl, 'Securing women's homes. The dynamics of women's human rights at the international level and in Tanzania', PhD thesis, University of Oslo, Faculty of Law (2010).
[5] WHO, *Trends in Maternal Mortality: 1990 to 2010 WHO, UNICEF, UNFPA and The World Bank Estimates*, 2012 at 4.
[6] CEDAW Committee, Communication No. 17/2008, 10 August 2011, para. 7.3.
[7] UNICEF, WHO and the United Nations Fund for Population Activities (UNFPA), *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997.

predicted or prevented, all pregnant women need access to good-quality emergency obstetric services.[8]

It is estimated that 287,000 maternal deaths occurred worldwide in 2010. Between 1990 and 2010 maternal deaths worldwide dropped 47 per cent, from 543,000 annually.[9] This is a significant reduction. In developing countries the maternal mortality ratio (MMR)[10] is 240 per 100,000 births, while it is 16 per 100,000 births in developed countries.[11] Of these deaths 56 per cent occurred in sub-Saharan Africa, and 29 per cent in Southern Asia. Two countries account for a third of maternal deaths: India (19 per cent, 56,000 maternal deaths in 2010) and Nigeria (14 per cent, 40,000 maternal deaths in 2010).[12] MMRs show greater disparity among countries than any other public health indicator, also within the sub-Saharan region, indicating important differences among countries as well as complex causal relations.[13] Even in relatively prosperous countries the MMR is sometimes very high.[14] For each woman who dies, many more suffer from acute or chronic illness and disability, in addition to the suffering of children and families.

3 Maternal deaths: causes and medical actions

According to WHO, maternal deaths are caused by complications during and following pregnancy and childbirth. Most complications develop during pregnancy, while some complications exist before pregnancy but are worsened during pregnancy. The major complications, accounting for 80 per cent of all maternal deaths, are preventable if specific medical actions are taken:

[8] J. Meyers, S. Lobis and H. Dakkak, 'UN process indicators: key to measuring maternal mortality reduction', *Forced Migration Review* 19 (2004) 16–18, at 16.

[9] WHO, *Trends in Maternal Mortality: 1990 to 2010* at 1.

[10] Number of maternal deaths during a given time period per 100,000 live births during the same time period. See WHO, *Trends in Maternal Mortality: 1990 to 2010* at 6.

[11] WHO, Fact Sheet No. 348, May 2012.

[12] *Ibid*.

[13] J. L. Alvarez, R. Gil, V. Hernández and A. Gil, 'Factors associated with maternal mortality in Sub-Saharan Africa: an ecological study', *BMC Public Health*, 2009, 462ff., available at: www.biomedcentral.com; R. Cook, B. M. Dickens and M. F. Fathalla, *Reproductive Health and Human Rights* (Oxford: Clarendon Press, 2003) at 24.

[14] E. Durojaye, 'Monitoring the right to health and sexual and reproductive health at the national level: some considerations for African governments', *Comparative and International Law Journal of Southern Africa* 42:2 (2009) 227–64 at 228.

(1) Severe bleeding (mostly after childbirth), which can kill a healthy woman within two hours if she is unattended. Injecting oxytocin immediately after childbirth effectively reduces the risk of bleeding.
(2) Infections (usually after childbirth). Good hygiene and treatment of early signs of infection can eliminate this risk.
(3) High blood pressure during pregnancy (pre-eclampsia and eclampsia). Pre-eclampsia should be detected and appropriately managed before the onset of convulsions (eclampsia) and other life-threatening complications. Administering drugs such as magnesium sulphate for pre-eclampsia can lower the risk of developing eclampsia.
(4) Obstructed labour occurs when the head of the baby is too big for the mother's pelvis or if the baby is abnormally positioned for birth. Partography (a graph of the progress of labour and the maternal and fetal condition) is a simple and effective tool for identifying these problems early in labour. Used by skilled practitioners, this tool can identify and manage obstructed labour before the lives of the mother and baby are in danger. If necessary, a caesarean section can be performed.
(5) Unsafe abortion. Many girls and women die due to infections or other damage caused by unsafe abortion procedures. Prevention of unwanted and too-early pregnancies is vital, as well as help in case of unwanted pregnancy. All women, including adolescents, need access to family planning, safe abortion services without risk of social or legal sanctions, and quality post-abortion care.[15]

The remaining deaths (20 per cent) are caused by diseases such as malaria and AIDS during pregnancy.[16] Maternal health and newborn health are closely related. More than three million newborn babies die every year, while an additional 2.6 million babies are stillborn.[17]

Most maternal deaths (80 per cent) are avoidable, since the medical solutions to prevent or manage complications are well documented and well known. All women need access to antenatal care in pregnancy and skilled care during childbirth, as well as care and support in the weeks after childbirth. The main problem is that women do not have access to a functioning health system providing timely and appropriate maternal healthcare, including emergency obstetric care performed by skilled

[15] WHO, Fact Sheet No. 348, May 2012.
[16] *Ibid*.
[17] *Ibid*.

personnel and access to safe abortions.[18] According to WHO, it is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death.[19] There is also a strong correlation between basic education, public spending on health and access to safe drinking water, and the reduction of maternal mortality.[20]

4 International initiatives, developments and MDGs

In an article entitled 'Maternal mortality: a neglected tragedy. Where is the "M" in MCH?', Rosenfield and Maine drew attention to the 'inherent neglect of women in maternal and child health (MCH) programmes'.[21] In 1987 the International Conference on Safe Motherhood in Nairobi led to the establishment of the Safe Motherhood Initiative, which aimed to find solutions to persistent maternal mortality and morbidity. When the United Nations (UN) International Conference on Population and Development (ICPD) was held in Cairo in 1994, 179 countries agreed on strategies to improve women's reproductive health within a human rights framework. At the Fourth World Conference on Women in Beijing in 1995, the *Beijing Declaration and Platform of Action* was adopted, addressing women's health in a broad human rights framework in which reproductive rights and empowerment of women were central. In 1997 the United Nations International Children's Emergency Fund (UNICEF), WHO and the United Nations Fund for Population Activities (UNFPA) developed a second edition of the *Guidelines for Monitoring the Availability and Use of Obstetric Services*,[22] which focuses on the ability of the health-care system to respond to women's needs for care.

Then, at the Millennium Summit in 2000, called to address serious global concerns, all 189 UN Member States adopted the UN Millennium Declaration on 8 September, stating inter alia that by the year 2015 they intended 'to have reduced maternal mortality by three quarters, and

[18] V. Boama and S. Arulkumaran, 'Safer childbirth: a rights-based approach', *International Journal of Gynaecology and Obstetrics* 106:2 (2009) 125–7 at 126.

[19] WHO, Fact Sheet No. 348, May 2012.

[20] Alvarez *et al.*, 'Factors associated with maternal mortality in Sub-Saharan Africa'.

[21] S. Gruskin, J. Cottingham, A. M. Hilber, E. Kismödi, O. Lincetto and M. J. Roseman, 'Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach', *Bulletin of the World Health Organization* 86:8 (2008) 589–93 at 590.

[22] United Nations International Children´s Emergency Fund (August 1997).

under-five child mortality by two-thirds, of their current rates' (section 19). This goal is situated in a context of human rights values and principles in that the Declaration also resolves 'to promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable' (section 20). The Millennium Declaration as such is based on the values and principles of human dignity, equality and equity, respect for human rights and fundamental freedoms, and respect for the equal rights of all without distinction to race, sex, language or religion (sections 1 and 2). The ambitious goal concerning reduction of maternal mortality by 2015, and other goals (related to poverty, health, peace, security, environment, human rights and democracy), were later encapsulated in the Millennium Development Goals (MDGs), endorsed by the UN General Assembly in 2001. At the 2005 World Summit the goals of universal access to reproductive health, as well as the goal concerning reduction of maternal mortality, were repeated. Specific references to the International Conference on Population and Development (ICPD) and *Beijing Declaration and Platform of Action* were made.[23] The human rights community, that is the Committees of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the CEDAW, the UN High Commissioner for Human Rights, the Human Rights Council and the UN Special Rapporteur on Health, became involved with the issue of maternal mortality from 2000 onwards.[24] In 2010 the UN Secretary-General launched the *Global Strategy for Women's and Children's Health*[25] in order to mobilize governments, civil society organizations and development partners to accelerate progress towards MDGs 4 and 5 (reduce child mortality and improve maternal health). A high-level Commission on Information and Accountability for Women's and Children's Health was established to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health.

[23] Resolution adopted by the General Assembly, 60/1, World Summit Outcome, 24 October 2005, paras. 57(g) and 58.

[24] See overview in R. J. Cook and V. Undurraga, 'Article 12' in M. A. Freeman, C. Chinkin and B. Rudolf (eds.), *The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary* (Oxford University Press, 2012) 311–34 at 316–17.

[25] This document was developed under the auspices of the United Nations General-Secretary, Ban Ki-moon, with support and facilitation by The Partnership for Maternal, Newborn and Child Health. The *Global Strategy* was launched at the time of the UN Leaders' Summit for the Millennium Development Goals (MDGs) in 2010.

Despite international campaigns and increased attention, maternal health has been the MDG that has made the least progress.[26] In sub-Saharan Africa, maternal mortality was reported to have decreased by only 0.1 per cent annually, while the number of pregnancy-related complications resulting in extended illness or disability was over 15 million annually.[27] In some sub-Saharan African countries maternal mortality even increased as a result of HIV/AIDS and malaria.[28] The situation is improving, however, and according to WHO, a number of sub-Saharan countries halved their levels of maternal mortality from 1990 to 2010.[29] The UN observes that, despite progress, pregnancy remains a major health risk for women in several regions, in particular sub-Saharan Africa and Southern Asia, where skilled birth attendance is still low.[30] WHO concludes that the global maternal mortality ratio declined by 3.1 per cent per year until 2010, which is far from the annual decline of 5.5 per cent required to achieve MDG 5.[31] Globally, then of the countries with high maternal mortality achieved the MDG 5 of 75 per cent reduction of the maternal mortality ratio by 2010, and nine countries are 'on track'. Fifty countries are 'making progress', fourteen have made 'insufficient progress' (less than 2 per cent annual MMR decline) and eleven countries have made no progress.[32]

5 Maternal mortality and the right to health: instruments and monitoring bodies

5.1 Instruments

Maternal mortality raises several human rights issues, including women's rights to life and health, non-discrimination and participation. The focus here is on the right to health, in particular with regard to state responsibility for provision of healthcare services to women. A key aspect of human rights treaties is that states are made legally responsible and

[26] United Nations, *The Millennium Development Goals Report*, 2009.
[27] Boama and Arulkumaran, 'Safer childbirth'.
[28] D. Shaw, 'Women's right to health and the millennium development goals: promoting partnerships to improve access', *International Journal of Gynaecology and Obstetrics* 93:3 (2006) 207–15; Alvarez *et al*., 'Factors associated with maternal mortality in Sub-Saharan Africa'.
[29] WHO, Fact Sheet No. 348, May 2012.
[30] UN, *The Millennium Development Goals Report*, 2011 at 29–30.
[31] WHO, Fact Sheet No. 348, May 2012.
[32] WHO, *Trends in Maternal Mortality: 1990 to 2010* at 27.

accountable for their policies and actions, and that principles of accountability, non-discrimination, information and participation are to be implemented into domestic health policies and regulations. As for the normative content of the right to health, the legal starting points are Article 12 of the ICESCR and Article 12 of the CEDAW. Both provisions address important aspects of the right to health, which is further outlined and developed by the ICESCR and CEDAW monitoring bodies (see below). Article 12, paragraph 1 of the ICESCR is the original and general human rights provision on the right to health and state obligations:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Paragraph 2 mentions the steps to be taken by the States Parties in order to achieve the full realization of the right to health, and shall include those necessary for:

(a) the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
(b) the improvement of all aspects of environmental and industrial hygiene;
(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and
(d) the creation of conditions that would ensure all medical service and medical attention in the event of sickness.

Article 10, paragraph 2.1 of the ICESCR states that special protection should be accorded to mothers during a reasonable period before and after childbirth. This provision includes basic maternal healthcare services.

No direct reference is made to women in Article 12 of the ICESCR; only indirect mention is made of the stillbirth rate, infant mortality and the healthy development of the child, and to ensuring all medical service and attention in case of 'sickness'. Maternity is not a disease, however, but a normal condition for women. The provision concerning women and health in Article 12 of the CEDAW is far more specific and women-centred:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

While paragraph 1 focuses on formal equality in the field of healthcare, paragraph 2 addresses the need of sex-specific healthcare services in order to achieve *substantive* equality for women.

Article 14 of the CEDAW is also important, especially in light of the fact that poor women in rural areas are particularly vulnerable with regard to lack of access to healthcare services:

> States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas … and, in particular, shall ensure to such women the right … [t]o have access to *adequate health care facilities*, including information, counselling and services in family planning … [t]o enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, *transport and communication*.[33]

The latter is important in light of the fact that many women die in childbirth because they lack transportation to hospital or even money to pay for such transportation (see below).

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003) – of particular relevance in the African context – is the first human rights instrument that articulates women's reproductive rights as human rights, and which expressly guarantees women's right to control their fertility. Article 14 contains important provisions for women's sexual and reproductive health, including a provision on a state's duty to take appropriate measures to 'establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding'. The Protocol also protects women's rights in relation to HIV/AIDS. The normative content of this provision is similar to what follows from the CEDAW, but is more elaborate with regard to the particular content of reproductive rights.

5.2 The role of the monitoring human rights bodies

In order for human rights to be effective, governments must show sufficient commitment to respect, protect, fulfil and promote them at the

[33] Para. 2(b) and (h), emphasis added.

domestic level. State accountability means that States Parties may be held legally and politically accountable for their health policies, programmes and strategies, in terms of the state report system, individual complaints procedures and political accountability at the national level (being confronted with the state obligations by NGOs, social movements and so on).

An important part of state accountability is the state duty of regular reporting to the monitoring bodies under Article 16 of the ICESCR and Article 18 of the CEDAW. The role of the international monitoring bodies is to assess the efforts of states and thereby contribute to state accountability. Of particular importance are the state reporting procedures in which states periodically submit reports to the monitoring bodies in order for these to review the situation with regard to progress and difficulties, and give recommendations for future state actions ('constructive dialogue'). Many of the countries with high maternal mortality ratios have ratified international or regional human rights instruments and have taken on responsibilities of implementing the right to health for women. Many countries have also adopted measures – both legislative and policy related – to deal with challenges related to women's health. However, it has been questioned whether the steps taken are in line with the obligations imposed by human rights conventions.[34] With regard to maternal deaths, this chapter illustrates the general observation that there is often a great disparity between states' ratification of human rights instruments and the actual implementation of the rights guaranteed. A common problem seems to be the lack of following up on state obligations and commitments at the governmental and domestic levels.[35]

In the following, I will examine key aspects of the right to health for women as this right is interpreted and elaborated by the ICESCR and the CEDAW monitoring bodies. As will be shown, both Committees provide relevant and well-informed comments and recommendations concerning the implementation of the right to health for women, including issues regarding maternal mortality. Both Committees link up and identify with the values and principles laid down in the UN International Conference on Population and Development (ICPD) in Cairo in 1994, and in the Fourth World Conference on Women in Beijing in 1995.[36]

[34] Durojaye, 'Monitoring the right to health' at 229.

[35] *Ibid*. T. Landman, 'Measuring human rights: principles, practice and policy', *Human Rights Quarterly* 26:4 (2004) 906–31 at 906–7.

[36] ICESCR Committee, General Comment No. 14 (2000), para. 2, note 3; CEDAW Committee, General Recommendation No. 24 (1999), para. 3.

The recommendations made by both Committees reflect the examination of many state reports and also the consideration of previous world conferences and programmes of action adopted by the UN. The CEDAW Committee emphasizes its collaboration with non-governmental organizations with special expertise in women's health in the preparation of the General Recommendation on health.[37]

6 Key aspects of the right to health: guidelines from the ICESCR and CEDAW Committees

The ICESCR Committee has in its General Comment No. 14 of 2000 given general and elaborate guidelines for understanding the state obligations following from Article 12. This document is the most comprehensive authoritative interpretation of the right to health at the UN level, although not formally binding.[38] As for the general content, the right to 'a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health' and 'timely and appropriate health care' (not a right to be healthy) is emphasized by the Committee, as well as the 'underlying determinants of health' (access to safe and potable water, adequate sanitation, adequate supply of safe food, secure housing, access to health-related information, popular participation in health-related decisions).[39] The right to health is understood as: 'a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[40]

This understanding is echoed by the many specific recommendations made by the CEDAW Committee.[41] The right to health is understood by both Committees in broad terms, including medical, physical, environmental and social aspects. Of particular interest concerning the state obligations is the Available, Accessible, Acceptable Services of Good Quality (AAAQ) framework.[42]

[37] CEDAW Committee, General Recommendation No. 24, para. 3.
[38] Articles 31–33 Vienna Convention on the Law of Treaties.
[39] ICESCR Committee, General Comment No. 14, paras. 8, 11.
[40] *Ibid*. at para. 9.
[41] CEDAW Committee, General Recommendation No. 24, paras. 11, 12, 13, 14, 17, 18, 19, 21, 22, 23, 24, 25.
[42] *Ibid*. at para. 12.

6.1 The AAAQ requirements

Of great importance concerning maternal health, morbidity and mortality is the AAAQ framework, which is systematically developed by the ICESCR Committee in General Comment No. 14, and on which the CEDAW Committee also draws heavily.[43]

Functioning public health and healthcare facilities, goods and services, as well as underlying determinants of health, must be *available* in sufficient quantity within the State Party, especially for women. The precise nature of facilities, goods and services may vary depending on several factors, including development and resources. In many countries, good-quality reproductive and abortion services are not available at all. From the perspective of women, the requirement of *accessible* reproductive healthcare services and facilities is also urgent. Accessibility means that everyone within the jurisdiction of the State Party must have access to services and facilities. According to General Comment No. 14, paragraph 12, accessibility has four dimensions:

(1) Non-discrimination: healthcare services and facilities must be accessible for all, especially the most vulnerable or marginalized groups, *de jure* and de facto. This is a crucial point in our context: in many countries with high maternal mortality appropriate healthcare services are not accessible for socially disadvantaged women, especially poor and rural women.
(2) Physical accessibility: healthcare services and facilities must be within safe physical reach for all sections of the population, especially for vulnerable or marginalized groups. Healthcare services and underlying determinants of health must also be developed in rural areas. In regard to maternal mortality, many women do not reach maternal healthcare facilities in time due to distance and lack of transportation.
(3) Economic accessibility: services must be affordable for all. Payment for healthcare services, as well as services related to underlying determinants of health, must be based on the principle of equity, ensuring that these services (whether public or private) are affordable for all, including for socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with

[43] See also Cook and Undurraga, 'Article 12'.

health expenses as compared to richer households. Costs are among the main reasons why poor and disadvantaged women do not seek professional healthcare.

(4) Information accessibility: everyone has a right to seek, receive and impart information and ideas concerning health issues. A general problem in many countries is the lack of appropriate information concerning reproductive healthcare issues and rights.

The ICESCR Committee notes that States Parties are to undertake 'actions that create, maintain and restore the health of the population', and that 'public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas'.[44]

The CEDAW Committee consistently emphasizes the state's obligation to ensure that policies and laws facilitate equal access to healthcare for women and girls, including sexual and reproductive health services, in a non-discriminatory and gender-sensitive manner.[45] Physical and economic access is highlighted:

> States parties should report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport.[46]

The CEDAW Committee stresses the need for free services in order to secure access to necessary services for women, and the duty of the States Parties to ensure to women their right to safe motherhood:

> States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's rights to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.[47]

[44] ICESCR Committee, General Comment No. 14, paras. 37, 36.

[45] CEDAW Committee, General Recommendation No. 24, paras. 11, 12, 13, 14, 17, 18, 19, 21, 22, 23, 24, 25.

[46] *Ibid*. at para. 21. [47] *Ibid*. at para. 27.

According to the CEDAW Committee, studies 'which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care'.[48] The Committee requests States Parties to report on what they have done to address the magnitude of women's ill health, in particular when it arises from preventable conditions.[49] State reports should include what measures States Parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the postnatal period. Information on the rates at which these measures have in fact reduced maternal mortality and morbidity in their countries, in general, and for vulnerable groups, regions and communities, in particular, should also be included.[50]

Another important element in the AAAQ scheme is the requirement for *acceptable* services of good *quality*. Acceptability implies respect for medical ethics, that services are culturally appropriate, sensitive to gender and life-cycle requirements, and that services must be designed to improve the health status of those concerned. The CEDAW Committee elaborates on these requirements with regard to women:

> States parties should also report on measures taken to ensure access to quality health care services, for example, by making them acceptable to women. Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.[51]

The guidelines provided by both Committees are highly relevant concerning maternal mortality, as many women experience disrespectful and poor-quality treatment, and therefore choose to stay away from public health facilities. When it comes to *quality*, scientifically and medically appropriate services are required, including skilled medical staff, approved drugs and hospital equipment, safe and potable water, and adequate sanitation. Lack of skilled medical attendance in emergency obstetric situations is considered one of the major reasons for the high incidence of maternal mortality.

The CEDAW Committee has raised maternal mortality as a human rights concern several times, for example with regard to Cambodia, Sierra Leone, Peru and Azerbaijan.[52] The state report submitted to the CEDAW

[48] *Ibid*. at para. 17. [49] *Ibid*. [50] *Ibid*. at para. 26.
[51] *Ibid*. at para. 22. [52] Cook and Undurraga, 'Article 12' at 316.

Committee in 2004 by Malawi, which is among the countries with highest maternal mortality in the world, illustrates many of the problems and barriers addressed by the AAAQ framework concerning physical and economic access as well as acceptable care:

> In addition to the insufficient health facilities, women in Malawi face problems to access health facilities, services, and goods. The poor access of women to health care is exacerbated by poor transport network, lack of transport money and time to travel to the health facility … [T]he attitude of health providers is another reason for people not attending health services. Many health providers are known to be rude, harsh, and discriminatory. In some cases, women are mishandled during childbirth … Health workers, particularly women, are overworked in health facilities. In maternity wards, patients indicated that men health workers were more caring, possibly because men are summoned only during complications and do not bear as heavy burdens as the women health workers.[53]

The Malawi state report also notes discrimination based on social status: people who are poor, especially women, are discriminated against in favour of those with higher social status including men. In most health centres women have to stand in long queues for treatment.[54] The CEDAW Committee expressed concern about the lack of access for women and girls to adequate healthcare services, particularly in rural areas, and 'is alarmed at the persistent high maternal mortality rate, particularly the number of deaths resulting from unsafe abortions, high fertility rates and inadequate family planning services, especially in rural areas, low rates of contraceptive use and lack of sex education'.[55] The Committee is also concerned that poverty and poor socio-economic conditions are among the causes of the violation of women's human rights and discrimination against women, especial in rural areas and, inter alia, with regard to access to healthcare.[56] The Committee thus:

> urges the State party to continue its efforts to improve the country's health infrastructure and to ensure sufficient budgetary allocations for accessible health services. It calls on the State party to integrate a gender perspective in all health sector reforms, while also ensuring that women's sexual

[53] Combined second, third, fourth and fifth periodic reports of Malawi, 28 June 2004, sections 12.3.3–12.3.4.
[54] *Ibid*. at sections 12.4.1–12.4.2. See also the combined initial, second, third, fourth and fifth periodic reports of Sierra Leone, 14 December 2006, section 19.2.1.
[55] *Concluding Comments of the CEDAW Committee: Malawi*, 3 February 2006, para. 31.
[56] *Ibid*. at para. 33.

> and reproductive health needs are adequately addressed. In particular, the Committee recommends that the State party undertake appropriate measures to improve women's access to health care and health-related services and information, including access for women who live in rural areas. It calls upon the State party to improve the availability of sexual and reproductive health services, including family planning information and services, as well as access to antenatal, post-natal and obstetric services to reduce maternal mortality and to achieve the Millennium Development Goal to reduce maternal mortality.[57]

The Committee did not in this communication directly address the availability of abortion services, but has since made more direct comments on the abortion issue in its communications (see below in 6.2).

The periodic report of Sierra Leone, which is another country with one of the highest maternal mortality ratios in the world, gives information on the following factors that hinder women's access to basic healthcare services and facilities: lack of recognition of the problem in time (10.5 per cent); husband, partner or relatives did not allow the woman to go to hospital (5.3 per cent); no transportation to take women to hospital (21.0 per cent); no competent staff to manage the obstetric problem (21.0 per cent); no blood available for transfusion (10.5 per cent); the women could not afford the cost of treatment (5.3 per cent).[58]

Clearly, a proper implementation of the AAAQ framework described above would contribute to a reduction of maternal mortality.[59] The CEDAW Committee recommends that Sierra Leone assess the actual causes of maternal mortality and set targets and benchmarks within a timeframe for its reduction. It urges the State Party to make every effort to raise awareness of and increase women's access to healthcare facilities and medical assistance by trained personnel, especially in rural areas and particularly in the area of postnatal care. The Committee further

[57] *Concluding Comments of the CEDAW Committee: Malawi* (Thirty-fifth session, 2006), para. 224.

[58] Report to the CEDAW Committee of November 2006 (at 66) with reference to UNICEF. These listed causes of women's lack of access to adequate healthcare services together make up the so-called 'three delays model': delay in making the decision to seek help, delay in arriving at health facilities and delay in receiving treatment. See D. Maine, *Safe Motherhood Programs: Options and Issues* (New York: Center for Population and Family Health, Columbia University, 1991); A. E. Yamin, *Deadly Delays: Maternal Mortality in Peru. A Rights-based Approach to Safe Motherhood* (Cambridge, MA: Physicians for Human Rights, 2007); P. Hunt and J. Bueno de Mesquita, *Reducing Maternal Mortality. The Contribution of the Highest Attainable Standard of Health* (Human Rights Centre, University of Essex, 2007) at 8.

[59] Hunt and Bueno de Mesquita, *Reducing Maternal Mortality*.

recommends that the State Party implements programmes and policies aimed at providing effective access to contraceptives and family planning services.[60]

6.2 Non-discrimination and substantive equality

The principle of non-discrimination is an important aspect of the AAAQ framework, as well as an independent human rights principle. As mentioned above, non-discrimination is essential in order to ensure access for everyone to healthcare services. Both Committees address this issue. It is interesting to note that while the text in Article 12 of the ICESCR does not mention women, the ICESCR Committee states that this provision:

> may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.[61]

This observation is in line with the notion that non-discrimination and substantive equality require reasonable accommodation for differences – between men and women, between urban and rural women, between rich and poor women (e.g. with regard to transportation to health facilities and costs).[62] Thus, the distinct needs of women with regard to maternal healthcare and reproductive services must be taken into account when interpreting and implementing the right to health.

Furthermore, the ICESCR Committee emphasizes that in order to eliminate discrimination against women:

> there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span … A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.[63]

Thus, the Committee argues for *transformative* equality in terms of a restructuring of the health service to accommodate the needs of women.

[60] CEDAW/C/SLE/C0/5 (2007), para. 35.
[61] ICESCR Committee, General Comment No. 14, para. 14.
[62] Cook and Undurraga, 'Article 12' at 325.
[63] ICESCR Committee, General Comment No. 14, para. 21.

In line with the CEDAW, this could also include dismantling demeaning stereotypes of women and groups of women in the health sector.[64] In its General Comment No. 16 of 2005,[65] addressing substantive issues arising in the implementation of the ICESCR concerning the equal rights of men and women (Article 3), the Committee gives specific examples of state obligations. With regard to the implementation of Article 3 of the ICESCR in relation to Article 12, a minimum requirement is the removal of legal and other obstacles that prevent men and women from accessing and benefiting from healthcare on a basis of equality, such as the removal of legal restrictions on reproductive health provisions and the provision of adequate training for health workers to deal with women's health issues.[66]

Likewise, the CEDAW Committee points out the obligation of states to 'eliminate discrimination against women in their access to health care services, throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period'.[67] The CEDAW Committee specifies the principle of non-discrimination with regard to state obligations, being even more articulate than the ICESCR Committee about the discriminatory nature of refusing certain reproductive healthcare services urgent to women:

> Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.[68]

[64] Cook and Undurraga, 'Article 12' at 325.
[65] E/C.12/2005/4, August 11, 2005.
[66] General Comment No. 16, para. 29.
[67] CEDAW Committee, General Recommendation No. 24, para. 2.
[68] *Ibid*. at para. 11. In Communication No. 17/2008, 10 August 2011, the CEDAW Committee concludes that a woman who was denied appropriate maternal care was discriminated against not only on the basis of her sex, but also on the basis of her African descent and her socio-economic background (para. 7.7). This decision and a recent decision on lack of access to therapeutic abortion is discussed by E. Kismödi, J. B. de Mesquita, X. A. Ibañez, R. Khosla and L. Sepúlveda, 'Human rights accountability for maternal death and failure to provide safe, legal abortion: the significance of two ground-breaking CEDAW decisions', *Reproductive Health Matters* 20:39 (2012) 31–9.

Although abortion is not mentioned explicitly, it is clear that women's access to safe abortion is one of the main concerns, in addition to family planning and contraception. In the recommendations for government action, the CEDAW Committee specifies that the prevention of unwanted pregnancies should be achieved through family planning and sex education, and that maternal mortality should be reduced through safe motherhood services and prenatal assistance. Abortion is also mentioned: 'When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion.'[69] However, it is not only decriminalization of abortion that is necessary to protect the life and health of women, but also the provision of safe abortion services.[70]

The CEDAW Committee has, however, expressed a bolder attitude to the abortion issue in later communications with States Parties. In the Concluding Observations to Nepal's combined fourth and fifth state report, the Committee expressed inter alia deep concern about the persistence of an extremely high maternal mortality and morbidity rate, in particular among rural, poor and young mothers, the challenges in existing delivery services, especially emergency care, the poor nutrition and the high rate of unsafe abortion *despite the legalization of abortion* in 2002. The State Party was recommended to improve access to abortion services throughout the country.[71] Similarly, Zambia is recommended to provide women with access to good-quality services for the management of complications arising from unsafe abortions, which take place in spite of abortion laws that do not prohibit women from seeking safe abortions in health centres.[72] In another recent decision, the CEDAW Committee urges Peru to establish an appropriate legal framework that allows women to exercise their right to legalized therapeutic abortion under conditions that guarantee the necessary legal security, both for women and for health professionals.[73] As argued by Fredman, if a capabilities approach is adopted, 'it would be obvious that merely removing legal prohibitions

[69] CEDAW Committee, General Recommendation No. 24, para. 31c.

[70] The Human Rights Committee stated in Communication No. 1153/2003, 22 November 2005, that the failure of a hospital in Peru to provide a young girl with a therapeutic abortion amounted to a violation of Articles 7 and 17 of the ICCPR. See van Leeuwen in Chapter 8.

[71] CEDAW/C/NPL/CO/4–5 (2011), paras. 31–32.

[72] CEDAW/C/ZMB/CO/5–6 (2011), paras. 33–34.

[73] CEDAW Committee, Communication No. 22/2009, 25 November 2011, para. 8.17.

on abortion would not be sufficient to be sure that women are in fact in a position to choose an abortion'.[74]

6.3 Core state obligations of immediate effect

Article 2.1 of the ICESCR describes the nature of the general legal obligation undertaken by States Parties:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation … to the maximum of its available resources, with a view to achieve progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

In General Comment No. 3 of 1990 on the nature of state obligations,[75] the ICESCR Committee has specified that States Parties have obligations of conduct as well as obligations of result, and that some of the obligations are of immediate effect (core obligations): the non-discrimination principle and the duty to take 'deliberate, concrete and targeted' steps 'within a reasonably short time after the Covenant's entry into force for the States concerned', towards the full realization of the right to health.[76]

The CEDAW Committee specifies in General Comment No. 28 of 2010 on the core state obligations under Article 2 of the CEDAW that the obligation to *respect* women's rights requires that States Parties refrain from making laws, policies, regulations, programmes, administrative procedures and institutional structures that directly or indirectly result in the denial of the equal enjoyment by women of their human rights.[77] Health programmes and services that systematically fail to ensure women's rights according to Article 12 of the CEDAW indicate a direct violation of women's core right to health. In a recent case, the CEDAW Committee concluded that the lack of appropriate maternal health services in Brazil, which clearly failed to meet the 'specific, distinctive health needs and interests of women', not only constituted a violation of Article 12.2 of the CEDAW, but also discrimination against women under Article 12.1 and Article 2 of the Convention. The lack of appropriate maternal health

[74] This volume, Chapter 7 (section 5.1).
[75] 14/12/1990.
[76] ICESCR Committee, General Comment No. 3, paras. 1 and 2.
[77] Para. 9.

services was considered to have 'a differential impact on the right to life of women'.[78]

Of special importance in the context of maternal mortality is the notion that 'minimum essential levels of each of the rights is incumbent upon every State party', including essential primary healthcare.[79] In General Comment No. 14 of 2000, the ICESCR Committee gives the supplementary statement that reproductive, maternal (prenatal as well as postnatal) and child healthcare 'are obligations of comparable priority' as those of essential primary healthcare.[80] The CEDAW Committee has pointed out that core obligations with regard to maternal health policies include action- and result-oriented policies that are adequately funded. The policy must ensure strong and focused bodies within the executive branch to implement such policies.[81]

Among the core obligations of each ratifying state is the duty to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, 'addressing the health concerns of the whole population'.[82] The strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process. The ICESCR Committee specifies that the principles of *non-discrimination and participation* by individuals and groups in decision-making processes that may affect their development, must be an integral part of policies, programmes and strategies under Article 12.[83] Furthermore, the national strategy and plan of action shall include appropriate methods, 'such as right to health indicators and benchmarks, by which progress can be closely monitored'. Finally, the process by which the strategy and plan of action are devised, as well as their content, 'shall give particular attention to all vulnerable or marginalized groups'.[84]

6.4 Appropriate indicators and benchmarks

The ICESCR Committee underlines that in order for States Parties to live up to the Covenant, a national strategy with the formulation of policies,

[78] CEDAW/C/49/D/17/2008, 10 August 2011, para. 7.6.
[79] ICESCR Committee, General Comment No. 3, para. 10.
[80] ICESCR Committee, General Comment No. 14, para. 44.
[81] CEDAW/C/49/D/17/2008, August 2011, para. 7.6; with reference to General Recommendation No. 28, para. 28.
[82] ICESCR Committee, General Comment No. 14, para. 43(f).
[83] *Ibid*. at para. 54. [84] *Ibid.at* para. 43(f).

health indicators and benchmarks are required.[85] States Parties must identify appropriate health indicators, and then set appropriate national benchmarks in relation to each indicator.[86] During the periodic reporting procedure, the Committee will 'engage in a process of scoping with the State party', which involves 'the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period'.[87] Thus, the national benchmarks are to be developed together with the state concerned, and according to realistic goals based on the particular circumstances of each state. In the following reporting process, 'the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered'.[88]

The UN and WHO have specified the following reproductive health indicators in developing regions: proportion of deliveries attended by skilled health personnel; proportion of women (15–49 years) attended at least once by skilled health personnel during pregnancy; proportion of women attended four or more times during pregnancy; number of births per 1,000 women aged 15–19; proportion of women who are using any method of contraception and have an unmet need for contraception and for family planning.[89] Sub-Saharan Africa, the region with the highest MMR and among the regions with the least proportion of skilled maternal care, also has the highest birth rate among adolescents and continues to have the lowest level of contraceptive prevalence.[90]

In its Concluding Comments concerning Malawi, a poor country with high maternal mortality, the CEDAW Committee calls for appropriate measures to prevent maternal deaths:

> The Committee urges the State party to continue its efforts to improve the country's health infrastructures and to ensure budgetary allocations for accessible health services. It calls on the State party to integrate a gender perspective in all health sector reforms, while also ensuring that women's sexual and reproductive health needs are adequately addressed. In particular, the Committee recommends that the State party undertake

[85] *Ibid*. at para. 53.
[86] See J. Asher, *The Right to Health: A Resource Manual for NGOs* (Commonwealth Medical Trust, 2004) at 89–97, concerning indicators and benchmarks.
[87] ICESCR Committee, General Comment No. 14, para. 58.
[88] *Ibid*.
[89] UN, *The Millennium Development Goals Report*, 2011 at 29–33.
[90] *Ibid*.

> appropriate measures to improve women's access to health care and health-related services and information, including access for women who live in rural areas. It calls upon the State party to improve the availability of sexual and reproductive health services, including family planning information and services, as well as access to antenatal, post-natal and obstetric services to reduce maternal mortality and to achieve the Millennium Development Goal to reduce maternal mortality.[91]

It seems unrealistic that Malawi will be able to reduce the maternal mortality rate by two-thirds by 2015. However, if the country adopts appropriate and effective measures in line with the UN, WHO and CEDAW Committee recommendations, it could change the devastating situation with regard to maternal mortality. According to WHO and UN estimates, Malawi is not on track, but is making progress.[92]

When considering the periodic report of Sierra Leone, the CEDAW Committee recommends the State Party to 'step up its efforts to reduce the incidence of maternal and infant mortality rates', suggesting assessment of the actual causes of maternal mortality and setting targets and benchmarks within a timeframe for its reduction. It urges the State Party to make every effort to raise awareness of and increase women's access to healthcare facilities and medical assistance by trained personnel, especially in rural areas and particularly in the area of postnatal care.[93] WHO reports that the current progress is insufficient with regard to MDG 5, which means that the annual decline in MMR is less than 2 per cent.[94]

On a positive note, in June 2010 the Delhi High Court issued a groundbreaking decision establishing the right to maternal healthcare as a constitutionally protected right in India. This happened in response to two cases (*Laxmi Mandal* v. *Deen Dayal Harinagar Hospital*[95] and *Jaitun* v. *Maternity Home, MCD, Jangpura*[96]). Both cases were brought by the Delhi-based Human Rights Law Network (HRLN), which, together with the Center for Reproductive Rights, have striven to promote legal accountability for maternal deaths and morbidities.[97] In both cases the Delhi High Court highlights the government's failure to implement public health schemes. In the *Laxmi* case, a poor woman, Laxmi, died shortly

[91] *Concluding Comments of the CEDAW Committee: Malawi*, 3 February 2006, para. 32.
[92] WHO, *Trends in Maternal Mortality: 1990 to 2010* at 27 and 41.
[93] *Concluding Comments of the CEDAW Committee: Sierra Leone*, 11 June 2007, para.35.
[94] WHO, *Trends in Maternal Mortality: 1990 to 2010* at 27 and 43.
[95] Delhi High Court, W.P.(C) 8853/2008.
[96] Delhi High Court, W.P. No. 10700/2009.
[97] Center for Reproductive Rights, http://reproductiverights.org (last accessed 31 May 2012).

after giving birth unattended on a Delhi street. The baby barely survived. This took place despite the fact that maternal health services are supposed to be offered for free to poor women in government hospitals. The Court urged the government of Delhi to immediately create shelters to provide poor pregnant women with food and proper medical care to avoid women being compelled to give birth on the street. At a public hearing in October 2010, the Court ordered the government to establish five professionally managed shelter homes that would provide destitute, pregnant and lactating women with food and medical services twenty-four hours a day. The Delhi government resisted, responding that seven such shelters already existed; these were found not to be government-run. Emphasizing the government of India's obligation to protect the fundamental rights to life and liberty of its people under the Indian Constitution, the Court reacted, saying it cannot be a 'silent spectator … waiting for the government to move like a tortoise and allow destitute and lactating women to die on the streets of Delhi'.[98]

7 Concluding remarks

The unacceptable high maternal mortality ratio in many countries signifies that women's human dignity, basic needs and perspectives are not taken into account, and that public policies, social structures and healthcare services are discriminatory. It reflects the low status of women and provides sensitive indicators of inequality, human rights violations and the powerlessness of women.[99] Effective protection of women's lives and health requires systematic state action in order to correct the social and structural injustices that deprive women of appropriate maternal and reproductive healthcare services. As pointed out by the CEDAW Committee, state policies and executive bodies on maternal health must be targeted as well as action- and result-oriented, and must be adequately funded.[100]

Neither ambitious goals at the highest international level (MDGs) nor engendered rights embedded in treaties and human rights jurisprudence automatically translate into basic healthcare services for women on the ground. There is a huge gap between formal ratification of the ICESCR

[98] Quoted from Center for Reproductive Rights, http://reproductiverights.org (last accessed 31 May 2012).

[99] Cook *et al.*, *Reproductive Health and Human Rights* at 32–3; Alvarez *et al.*, 'Factors associated with maternal mortality in Sub-Saharan Africa'.

[100] CEDAW Committee, Communication No. 17/2008, 10 August 2011, para. 7.6.

and the CEDAW, and appropriate domestic implementation of the right to health for women. With regard to maternal deaths, the main problem is not lack of medical knowledge and international regulation, but rather lack of governmental commitment, follow-up and state accountability for making targeted steps and priorities. Regulations, policies and programmes, including the AAAQ human rights requirements, are not put in place, although they most likely would reduce the sad statistics of women's deaths, morbidity and related suffering. As for the African region, the Maputo Protocol on women's reproductive rights seems to be seriously neglected by many governments.

In general, human rights principles are believed to make a significant contribution to global social reform in several areas, including aid effectiveness in the area of health.[101] A study by Ferguson suggests that the utilization of the human rights framework can strengthen aid effectiveness and improve development outcomes in the health sector. Critical issues such as maternal mortality should, according to the author, be discussed by use of the human rights framework, including international human rights reporting mechanisms. In order to ensure equality and the prioritization of primary healthcare services, health sector budgets should make reallocations on the basis of principles of equality.[102] This is in line with the recommendations of the CEDAW Committee.

According to the South African public health physician Helen de Pinho, 'a rights-based approach does shape how governments respond to the crisis of maternal death in a manner that is fundamentally different to the efficiency-driven neo-liberal approach experienced over the past four decades'.[103] She asserts that this approach requires states to reject the notion of health and healthcare as a commodity to be bought and sold in a market. Rather, a rights-based approach to maternal health requires an acknowledgement of the power dynamics in the structuring of health outcomes (such as maternal deaths). The human rights framework holds governments accountable, exposes rights violations, and defines principles

[101] R. Bösch, 'Human rights and aid effectiveness' in A. Clapham *et al.* (eds.), *Realizing the Right to Health* (Zurich: Rüffer and Rubb, 2009) 446–61 at 459; S. E. Merry, *Human Rights and Gender Violence: Translating International Law into Local Justice* (University of Chicago Press, 2006).

[102] C. Ferguson, *Human Rights and Aid Effectiveness: Inter-linkages and Synergies to Improve Development Outcomes in the Health Sector* (Report for the Human Rights Task Team, OECD/DAC GOVNET, 2008).

[103] H. de Pinho, 'On the "rights" track: the importance of a rights-based approach to reducing maternal deaths' in A. Clapham *et al.* (eds.), *Realizing the Right to Health* 111–20 at 116.

and values for the progressive realization of the right to health. According to de Pinho, the human rights principles of equity, transparency, accountability, participation and non-discrimination provide the values against which maternal health policies should be measured. Contrary to the MDGs, which are not necessarily based on human rights principles, a rights-based approach 'promotes systemic long-term health system planning centred around a functioning health system necessary for sustained maternal mortality reduction'.[104] As pointed out by Kismödi *et al*., international human rights mechanisms are of particular importance when 'domestic accountability is absent, inaccessible or ineffective'.[105]

The rights-based approach identifies rights-holders and duty-bearers, and make states accountable for the realization of the right to health. A rights-based approach to women's reproductive and sexual health indicates that responsibility does not only fall on individuals, but also on governments and other authorities to ensure availability, accessibility, acceptability and good quality of necessary services.[106] State accountability is an essential strategy in the attempt to reduce maternal mortality and morbidity.[107]

Proper national monitoring systems, including the provision of reliable and disaggregated data, are essential in order to make central and local governments accountable for their policies.[108] Human Rights Watch, in its report *Stop Making Excuses: Accountability for Maternal Health Care in South Africa*,[109] has documented maternity care failures that include abuse of maternity patients by health workers and substandard care, putting women and their newborns at high risk of death or injury. It examines shortcomings in the tools used by health authorities to identify and correct health system failures that contribute to poor maternal health. Other reports document similar lack of accountability for health system failures.[110] The high-level Commission on Information and Accountability

[104] *Ibid*.

[105] Kismödi *et al*., 'Human rights accountability for maternal death' at 37.

[106] I. Goicolea, M. S. San Sebastián and M. Wulff, 'Women's reproductive rights in the Amazon Basin of Equador: challenges for transforming policy into practice', *Health and Human Rights* 10:2 (2008) 91–103 at 91–2.

[107] Kismödi *et al*., 'Human rights accountability for maternal death' at 37.

[108] Bösch, 'Human rights and aid effectiveness' at 458; Goicolea *et al*., 'Women's reproductive rights in the Amazon Basin of Equador'.

[109] Report of 8 August, 2011, available at: www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care (last accessed 1 June 2012).

[110] See Center for Reproductive Rights and Women Advocates Research and Documentation Centre (New York, 2008), *Broken Promises: Human Rights, Accountability, and Maternal Death in Nigeria*, and Amnesty International, *Pregnant Women*

for Women's and Children's Health has recommended that, by 2015, all countries take significant steps to establish a system for the registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys. Today, only a third of countries worldwide have complete civil registration systems with good attribution of cause of death. In order to improve the estimation of maternal mortality, it is imperative that countries take steps to strengthen their registration and information systems.[111]

Authorities need to be held accountable for targets that are realistic and achievable at the level of their responsibility.[112] Ebenezer Durojaye discusses how to measure adherence to human rights in the African context, and recommends the framework developed by an international non-governmental organization, Peoples' Health Movement (PHM) as appropriate for monitoring the right to health including sexual and reproductive rights.[113] He concludes by arguing that civil society groups and human rights institutions need to work together with African governments to ensure proper monitoring of sexual and reproductive rights at the national level. The community-based study performed by Goicolea *et al*. in the province of Orellana in Ecuador concludes that Ecuador's official data of accessibility to pregnancy-related services for women do not accurately represent isolated areas, and that the use of national-level data for monitoring access 'prevents the disclosure of inequalities'.[114] The study indicates that local initiatives for data collection are feasible and may yield information that is more suitable for monitoring and designing interventions. The study also identifies a significant gap between national policies and the reality for women respectively, explained by reference to the lack of targets and inadequate discussions of resources and responsibilities for involved parties. The authors conclude that accountability for sexual and reproductive health and rights in isolated, impoverished areas such as Orellana depends on 'meaningful, accurate, and disaggregated information, and the development of mechanisms to ensure that citizens

in Burkina Faso Dying Because of Discrimination, Report 27 January 2010, available at: www.amnesty.org/en/news-and-updates/report/ (last accessed 1 June 2012).

111 WHO, *Trends in Maternal Mortality: 1990 to 2010* at 1.

112 M. Langford, 'A poverty of rights: six ways to fix the MDGs', *IDS Bulletin* 41:1 (2010) 83–91 at 89.

113 Durojaye, 'Monitoring the right to health'.

114 Goicolea *et al*., 'Women's reproductive rights in the Amazon Basin of Equador' at 99.

(especially those most vulnerable) can demand that their governments honor stated commitments'.[115] These observations support the CEDAW Committee's recommendations of assessment of actual causes of maternal mortality and give particular attention to rural areas.

Recent research suggests that international treaties 'can play an important role in changing rights outcomes when they impact domestic politics in certain ways'.[116] In fact, an important aspect of the human rights framework is to ensure and stimulate domestic and local participation as well as political and civil society mobilization.[117] In addition, in order for human rights to be effective, they need to be translated into local terms and situated within local contexts of power and meaning. As Sally E. Merry puts it: 'If human rights ideas are to have an impact, they need to become part of the consciousness of ordinary people around the world.'[118] The idea of women's rights to adequate maternal healthcare needs to be part of the general consciousness of women and men, healthcare providers, local governments and health ministries (see Article 5 of the CEDAW).

The recent court cases in India are promising with regard to transformative and substantive equality in the field of maternity protection, as they might have the effect that women's situations and right to necessary healthcare services become part of the public awareness and demands in India. Examining processes of local 'framing' and implementation of global human rights standards is crucial in order to understand the way human rights work in different contexts,[119] and also with regard to women's right to health: how are women's needs and access to maternal healthcare services assessed, understood and handled in different settings, which barriers exist, and how could these barriers most effectively be modified or eliminated in various contexts? Human rights frequently stress *individual* needs, but the health-seeking actions of pregnant women must be understood within the context of their families, communities and society at large, and with regard to the way healthcare services are commonly operated, perceived and evaluated at the local level. Concerning

[115] *Ibid*.

[116] B. Simmons, *Mobilizing for Human Rights: International Law in Domestic Politics* (Cambridge University Press, 2009) at 203.

[117] A. E. Yamin, 'Suffering and powerlessness: the significance of promoting participation in rights-based approaches to health', *Health and Human Rights* 11:1 (2009) 5–22. See also Byrnes, Chapter 1 (section 3) in this volume.

[118] Merry, *Human Rights and Gender Violence* at 3.

[119] *Ibid*. at 1.

public infrastructure, the lack of publicly accessible and good-quality reproductive services for all women, including abortion services, as well as multiple discrimination and economic constraints, are important barriers that States Parties must address properly in order to respect, protect and fulfil women's right to life and health.