**Alicia Ely Yamin[[1]](#footnote-1)**

**Technical Guidance launch event.**

**September 14, 2012.**

Good afternoon Madame High Commissioner, Excellency, distinguished fellow panelists, and honorable representatives. It is a tremendous honor for me to be here today at the historic launch of this ‘Technical Guidance on the Application of a Human Rights Based Approach to Maternal Mortality and Morbidity,’ and I am profoundly grateful to the High Commissioner for Human Rights for inviting me to participate on this panel.

Close to 20 years ago when I began work on maternal health and human rights, this day would have been unthinkable. I recall in fact being told by an international expert in those early days that to talk about women having a right to safe motherhood was as useful as trying to knit coats out of butterfly wings.

The only relevance human rights was thought to have to maternal health at the time related to issues of autonomy from coercive practices. There was not yet wide acceptance in most of the world that women had a right to access health care.

Indeed, it was not until the late 1990’s that official consensus was reached as to the interventions necessary to reduce maternal mortality and morbidity among the global public health community. The understanding that the great majority of obstetric complications were neither predictable nor preventable, but that they were in fact readily treatable with a handful of interventions was critical to the evolution of thinking about maternal mortality in terms of human rights. Just as with the advent of effective antiretroviral therapy, the difference between having access to emergency obstetric care—which has been provided for in the global North for decades—or not--meant the difference between life and death.

And therefore we could no longer pretend that it was just a misfortune when a woman died needlessly in childbirth. Just as with the denial of anti-retroviral therapy to people living with HIV /AIDS, the denial of access to life-saving care is a not just a tragedy; it is a profound injustice.

As critical-- as momentous-- as that shift in understanding was-- and is-- the importance of applying human rights to this subject goes far beyond emergency obstetric care. The vast majority of women who end up dying in pregnancy and childbirth have lived lives marked by deprivation and discrimination. From the moment of their births, these girls and women often face a funnel of narrowing choices whereby they are unable to exercise meaningful agency with respect to what they will do with their lives, how much they will be educated, with whom they will partner, when they will have sex, whether they will use contraception, and finally what care they will get when they are pregnant or delivering, even when their lives hang in the balance.

Adopting a rights-based approach to the reduction of maternal mortality and morbidity demands opening spaces for women and girls to exercise choices and calls for subverting the social -- and power --relations that deny them their full humanity. As was recognized by this illustrious body in documents adopted through previous resolutions, a human rights approach demands respect for a broad range of women’s sexual and reproductive rights, as was set out in the Programme of Action of the International Conference on Population and Development, and reiterated in many subsequent documents.

The Millennium Development Goals have focused the world’s attention on the magnitude of maternal mortality around the world. And in just the last few years there have been several critical milestones in acknowledging the centrality of human rights to sustainably addressing the scourge of maternal death and morbidity around the world.

None have been more important, in my view, than this Council’s extraordinary level of engagement with the issue of maternal mortality and human rights, which has played a fundamental role in forging linkages between the human rights and health fields on this topic, and in highlighting the importance of issues relating to voice, gender equality and accountability. The previous reports prepared for the Council by the Office of the High Commissioner have made very clear that women and girls are not continuing to die and suffer lifelong disability because we don’t know what to do about this problem. They are continuing to die in massive numbers because they still face discrimination in their households, communities and societies and because their voices are not listened to and their lives are not valued.

The Technical Guidance being launched today is both the logical extension of the Council’s engagement on the topic thus far, and also truly ground-breaking—as it moves beyond that analysis of why women are dying, beyond the principles of human rights texts, to translate those norms and that analysis into concrete guidance to policy makers as to what to do.

If we are really to bring to bear the tools and power of human rights to address preventable maternal mortality and morbidity, this Technical Guidance must be the next step. With the greatest respect, I submit that we must now move this subject out of these hallowed halls, to the ministries in country where the decisions that affect whether women live or die are really taken. That shift is what this Technical Guidance can facilitate.

Even with the greatest political will, policy-makers within and beyond the health sector must be able to understand how a rights-based approach would be different than a conventional public health approach to maternal mortality at every stage of the policy making cycle, from a situational analysis to national planning processes, to budget formulation and allocation, to implementation of programs, to monitoring and evaluation, to remedies. That, as we have heard, is what this Technical Guidance does.

And it is important to recall that we already have examples of how concern for rights principles, coupled with best practices in public health, can shift government approaches.

For example, in Nepal, the government adopted a national plan and specific policies that explicitly affirm a human rights-based approach. Not only does the approach situate maternal health along a continuum of care but it also adopts a multi-sectoral strategy, including transport, communication and development. Further, gender equality strategies have been incorporated across government departments, not just health. And Nepal has made significant progress on maternal health related indicators.

With regard to budgeting, both in very low income as well as middle- / high-income countries, governments have identified costs as a barrier to accessing reproductive and maternal health services. In Mexico, an OECD country, a new public insurance scheme, Seguro Popular, was established in 2003 which assures access to a comprehensive package of essential services. Grounded explicitly in the conviction that health care is a right, the Seguro Popular has been called “an instrument for empowering people by making them aware of their entitlements”. An evaluation of the initial results of this insurance reform revealed “a robust, significantly positive impact on access to obstetrical services.”

Similarly, in Sierra Leone, where user fees had been identified as a major obstacle in reducing maternal mortality, preliminary data indicates that the government’s elimination of out-of-pocket payments for pregnant women has also increased use of the formal health system substantially with respect to obstetrical services.

In Kenya, after the Kenyan Commission on Human Rights documented the need for provider-friendly guidelines and standards of practice, the Kenyan Skilled Care Initiative was launched which included training for maternal health care workers in both technical standards and a human rights-based approach to provision of services. The program included a review of key rights principles drawn from Kenya's own ministerial guidelines and regulatory frameworks, and there is some evidence that this program is helping to foster greater accountability of service providers.

In Peru, the National Human Rights Ombuds office—the Defensoría del Pueblo— has also played a pivotal role in advancing a rights-based approach to maternal health. In 2007, the Defensoría created a special unit on maternal health and began documenting quality of care and other problems in health facilities and channeling local community members’ participation into policy recommendations at the district and regional health planning levels. Citizen participation in health was also enhanced in Peru by the legislature’s recent reform of the CLAS law—the law on Local Committees for the Administration of Health—which enable communities to audit their local health facilities and play a role in decisions taken

The adoption of this Technical Guidance will no doubt encourage many more countries to implement such changes to promote greater inter-sectoral coordination, equality of access, participation, and accountability among other things. It will also set an important precedent –and demonstrate the possibilities for—concretely incorporating human rights into health and development practice-- including the roles and responsibilities of donors, as planning for a post 2015 development framework gets underway.

But this Technical Guidance is critical not just at the global and national levels, but also on the ground, at the level of the individual and the family.

With support from the Hansen Family Foundation, my program at Harvard University is engaged in field research in 4 countries in eastern and southern Africa to examine the impacts of maternal mortality on children and families. Because when a woman dies, the suffering does not end there. Existing data is scarce—and we need to learn more about this-- but it suggests that there may be as much a five-fold increase in mortality of children up to the age of 10 whose mothers died in pregnancy and childbirth. In addition, preliminary findings suggest elevated levels of family dissolution, malnutrition, school drop-out rates, and early pregnancy. The toll that these deaths take on families, and the lost hopes of these children, are also the costs of inaction on maternal mortality.

In doing this field research, in interviewing surviving family members in villages in East Africa, as well as elsewhere over the years, what always strikes me is how many of them say that their wife’s or sister’s or daughter’s or aunt’s or mother’s death was ‘the will of God’.

I do not believe it is the will of God that so many young women should continue to die in Sub-Saharan Africa and South Asia and parts of Latin America, while many fewer die in Western Europe or North America. I do not believe it is the will of God that poor women and rural women should be consigned to risk their lives in giving birth while wealthy urban women largely are not.

I have cried with families who lost their mother because there was no transportation to a health facility; I have seen women die in maternity wards for lack of ability to pay for blood; I have sat with mothers who are raising their grandchildren after burying their daughters; I have held a young boy in my arms—about the same age as my own son—who will never be held by his own mother and will never know a home other than the orphanage he lives in.

These deaths are not the will of God; they are the result of human decisions and man-made policies. And these can be changed.

And I believe that the people who are most affected by those decisions and policies can --and will with time --come to see their entitlements as rights to be claimed, and not as charity.

This eminent body has a historic opportunity to take an important step toward fostering the transformation of people’s consciousness --and of their lives-- by adopting a resolution that urges governments to implement this Technical Guidance in their efforts to reduce preventable maternal mortality and morbidity.

Thank you very much.

1. Lecturer on Global Health and Director, Health Rights of Women and Children Program, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard University; Associated Senior Researcher, Christian Michelsen Institute (Norway) [↑](#footnote-ref-1)