

Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance



**UNITED NATIONS
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Summary

The present report contains concise technical guidance, in accordance with the request made by the Human Rights Council in its resolution 18/2. The aim of the report is to assist policymakers in improving women's health and rights by providing guidance on implementing policies and programmes to reduce maternal mortality and morbidity in accordance with human rights standards. It highlights the human rights implications for multiple actors in the policymaking, implementation and review cycle, as well as the need for robust enforcement mechanisms and international assistance and cooperation.

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I. Introduction

1. In its resolution 18/2, the Human Rights Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR), in cooperation with concerned United Nations agencies and other experts, to prepare concise 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, and to present it to the Council at its twenty-first session.

2. In 2011, OHCHR circulated a note verbale to all States and international organizations requesting information on existing technical guidance pertaining to human rights and maternal mortality and morbidity.¹ In addition to desk-based research, the present report was informed by responses to the note verbale, close cooperation with United Nations agencies, academics and civil society organizations working in the area of maternal mortality and morbidity, an expert group consultation and a public consultation.

3. Maternal mortality and morbidity continue to exact a terrible toll on women, and especially impoverished women, in many countries worldwide. Some 287,000 women died of maternal causes in 2010,² and between 10 and 15 million more suffer debilitating complications annually, severely affecting their well-being. The World Health Organization (WHO) estimates that from 88 to 98 per cent of maternal deaths are preventable.³

4. Millennium Development Goal 5 calls for a 75 per cent reduction in maternal mortality ratios from 1990 levels and universal access to reproductive health by 2015, the latter being the target that is most off-track.⁴ At the High-level Plenary Meeting of the

General Assembly on the Millennium Development Goals in 2010, the Secretary-General launched the Global Strategy for Women's and Children's Health to accelerate progress. As a result of the Global Strategy, an information and accountability commission was established, which issued a report recognizing the centrality of human rights to achieving progress, and made 10 recommendations, the implementation of which can support the guidance contained in the present report.⁵

5. The primary purpose of the present report is to assist policymakers in improving women's health and rights by providing guidance on devising, implementing and monitoring policies and programmes to reduce maternal mortality and morbidity, and fostering accountability in accordance with human rights standards.⁶

6. Although primarily aimed at health decision-makers, the guidance is also relevant to other sectors, including finance and education, as well as parliamentarians, judiciaries, inter-governmental agencies, national human rights institutions and donor States. The engagement of civil society is necessary for the effective implementation of the guidelines, and to hold Governments to account.

7. The High Commissioner encourages the implementation of the present technical guidance. The Human Rights Council could consider encouraging the dissemination of the guidance to all relevant parts of Government as well as other stakeholders and promoting its use in programmes and policies to eliminate maternal mortality and morbidity. The Council could also encourage inter-agency dialogue and collaboration within the United Nations systems

1 All submissions received are available on the OHCHR website at www2.ohchr.org/english/issues/women/.

2 World Health Organization (WHO), *Trends in Maternal Mortality: 1990 to 2010*. WHO, UNICEF, UNFPA and the World Bank Estimates, 2012. Available from www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

3 WHO, "Maternal mortality: helping women off the road to death", *WHO Chronicle*, vol. 40, 1986, pp. 175–183.

4 A/64/665, para 30.

5 *Commission on Information and Accountability for Women's and Children's Health, Keeping Promises, Measuring Results*, WHO, 2011 (available from www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf), p. 2.

6 Particular situations, such as emergencies, may require additional guidance with regard to compliance with human rights standards and other obligations under international law, including humanitarian law. See *Inter-agency Working Group on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010.

on the implementation of the guidance through their own policies, programmes and technical support.

II. General principles

8. Human rights are about empowerment and entitlement of people with respect to certain aspects of their lives, including their sexual and reproductive health. International human rights law includes fundamental commitments of States to enable women to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health rights and living a life of dignity. Sound public health practice is crucial to enable States to fulfil these basic rights, but it must be complemented by broader measures to address women's empowerment.

9. The present technical guidance builds on two previous OHCHR reports. In the first (A/HRC/14/39), OHCHR identified seven human rights principles fundamental for understanding maternal mortality and morbidity as a human rights issue: accountability, participation, transparency, empowerment, sustainability, international assistance and non-discrimination. In the second (A/HRC/18/27), OHCHR outlined categories of good practices to address maternal mortality and morbidity in compliance with human rights obligations: enhancing the status of women, ensuring sexual and reproductive health rights, strengthening health systems, addressing unsafe abortion, and improving monitoring and evaluation. The work of other human rights mechanisms has also been taken into account in the guidelines.⁷

10. A human rights-based approach identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations, and promotes strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations. These rights and obligations are provided for under international human rights law.

11. The technical guidance, like previous OHCHR reports, are grounded in the respect for sexual and reproductive health and rights, as set out in the Programme of Action of the International Conference on Population and Development⁸ and reiterated and expanded upon in subsequent United Nations documents and international law.

12. A human rights-based approach is about health and not isolated pathologies; it is premised upon empowering women to claim their rights, and not merely avoiding maternal death or morbidity. Express recognition of the right to health, including a comprehensive understanding of sexual and reproductive health in constitutions and/or legislation, together with accountability mechanisms for the vindication of health rights is essential to a rights-based approach.

13. Measures are required to address the social determinants of women's health that affect the enjoyment of civil, political, economic, social and cultural rights. In all countries, patterns of maternal mortality and morbidity often reflect power differentials in society and the distribution of power between men and women. Manifested in poverty and income inequality, gender discrimination in law and practice, and marginalization based on ethnicity, race, caste, national origin and other grounds are social determinants that affect multiple rights.

14. States must take all appropriate measures to eliminate discrimination against women, including gender-based violence, forced and early marriage, nutritional taboos, female genital mutilation/cutting and other harmful practices.⁹ Maternal mortality and morbidity is a product of discrimination against women, and denial of their human rights, including sexual and reproductive health rights.

⁷ A/HRC/17/25; CEDAW/C/49/D/17/2008; CEDAW/C/50/D/22/2009; Inter-American Commission on Human Rights, "Access to Maternal Health Services from a Human Rights Perspective", *Organization of American States*, 7 June 2010.

⁸ *Report of the International Conference on Population and Development, Cairo, 5–13 September 1994 (United Nations publication, Sales No. E.95.XIII.18)*, chap. I, resolution 1, annex.

⁹ *Convention on the Elimination of All Forms of Discrimination against Women*, art. 5; *Committee on the Elimination of Discrimination against Women*, general recommendation No. 14; *Committee on Economic, Social and Cultural Rights*, general comment No. 14 (E/C.12/2000/4), para. 21.

15. Human rights require “particular attention to vulnerable or marginalized groups”.¹⁰ Among other groups, adolescents, ethnic and racial minorities, indigenous women, women with disabilities, sex workers, HIV-positive women, displaced and war-affected women, women living in underserved areas and other stigmatized and excluded populations should be paid special attention.¹¹

16. Applying a rights-based approach to the reduction of maternal mortality and morbidity depends upon a just, as well as effective, health system. Health systems are more than delivery apparatus for interventions and commodities. A society in which rich and poor women alike – irrespective of race, ethnicity, caste, disability or other characteristic – can rely on the health system to meet their sexual and reproductive health needs fairly is a more just society. In turn, claims for sexual and reproductive health goods, services and information should be understood by health system users, providers and policymakers as fundamental rights, not as commodities to be allocated by the market or matters of charity.¹²

17. In a human rights framework, women are active agents who are entitled to participate in decisions that affect their sexual and reproductive health. To be effective, participation should enable women to challenge political and other forms of exclusion that prevent them from exercising power over decisions and processes that affect their lives, including their sexual and reproductive health. This requires meaningful participation in the identification of problems, policy design and budget allocation, and the evaluation of programmes and policy implementation.

18. Accountability is not an afterthought in a rights-based approach, but fundamental to each stage of the process – from identifying accountability gaps in a situational analysis to ensuring appropriate monitoring mechanisms and remedies in a national

plan, to allocating resources for these mechanisms and remedies, to ensuring feedback from the ground through to implementation in practice. Lessons learned through structures of accountability must inform the continual process of adjusting existing programmes and future planning.

19. The design, organization and coordination of the components of the health system should be guided by fundamental human rights principles, including non-discrimination/equality, transparency, participation and accountability.¹³

20. Ensuring women’s sexual and reproductive health rights requires meeting standards with regard to health facilities, goods and services:

- (a) Availability of both the underlying determinants of health, as well as hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs;
- (b) Accessibility in four overlapping dimensions: physical, economic (affordable), non-discrimination, and regarding information;
- (c) Acceptability in terms of respect for medical ethics and of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;
- (d) Quality, including skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation;¹⁴ respectful care for women using health services is a critical dimension of both quality and acceptability.

10 E/C.12/2000/4, para. 43.

11 A/HRC/14/39, paras. 19-21.

12 Lynn Freedman, “Achieving the MDGs: health systems as core social institutions”, *Development*, vol. 48, No. 1, 2005, pp. 19-24. See also A/HRC/7/11.

13 WHO, *Everybody’s Business, Strengthening Health Systems to Improve Health Outcomes (2007)*. The six components identified by WHO are service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance.

14 E/CN.4/2000/4, para. 12 (a) – (d).

21. States are required to use “maximum available resources” for the progressive realization of economic, social and cultural rights; if resource constraints make it impossible for the State to fulfil women’s sexual and reproductive health rights immediately, the State must demonstrate that it has used all the resources at its disposal to do so as a matter of priority.¹⁵ Multiple obligations relating to sexual and reproductive health rights are not subject to resource availability, including obligations related to a national plan of action, and the elimination of harmful practices and discrimination.¹⁶ Those obligations subject to “progressive realization” require the adoption of all appropriate measures in a deliberate, concrete and targeted manner, within the “maximum available resources”, including resources from international cooperation.¹⁷ There is a strong presumption against any retrogressive measures in relation to sexual and reproductive health.¹⁸

22. States should protect against interference with sexual and reproductive health rights by third parties by enforcing appropriate laws, policies, regulations and guidelines. States are responsible for exercising due diligence, or acting with a certain standard of care, to ensure that non-governmental actors, including private service providers, insurance and pharmaceutical companies, and manufacturers of health-related goods and equipment, as well as community and family members, comply with certain standards.¹⁹ States may be held responsible for private acts if they fail to act with due diligence to prevent, investigate and punish violations of rights.²⁰

15 *Ibid.*, para. 47.

16 *Ibid.*, paras. 43 and 44; CEDAW/C/49/D/17/2008, para. 7.6.

17 *Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 13; see also Convention on the Rights of the Child, art. 24(4).*

18 *Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 32.*

19 *Committee on the Elimination of Discrimination against Women, general recommendation No. 28, para. 13.*

20 *Ibid.* See also *Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 9, and CEDAW/C/49/D/17/2008, paras 7.5 and 8.*

23. Where the health system is decentralized, the national Government remains accountable for complying with human rights obligations, including those relating to sexual and reproductive health.

III. Planning and budgeting

24. Public health planning traditionally begins with the acknowledgement of a maternal mortality and morbidity problem, and then goes on to propose how to address it within the current societal framework. Rights-based planning goes further by also examining the dominant assumptions underlying the structural determinants of women’s health, and then includes strategies to address those factors, to reshape the possibility frontier for advancing maternal health. A human rights-based approach therefore changes decision-making processes, and the issues and actors included in those processes, as well as outcomes.

25. A human rights-based approach requires a multi-sectoral approach to economic and social planning and budgeting, including, at a minimum, coordination among a variety of Government ministries and departments, as well as with other key actors, such as the private sector, development partners and civil society. Moreover, planning and budgeting processes cannot leave all decision-making to technical experts; full transparency and meaningful participation by the people affected are required for devising effective, democratically legitimate and sustainable solutions to the inevitable policy trade-offs.

A. PLANNING

26. Guaranteeing the right to health requires the State, as a core obligation, to adopt a national public health strategy and plan of action (national plan). The national plan, coordinated with subnational plans, must comprehensively cover the health needs of the entire population, clearly identifying responsible actors in various contexts and establishing accountability mechanisms.

27. The national plan must contain a sexual and reproductive health strategy, encompassing maternal health. It should reflect the pivotal importance of sexual and reproductive health, including maternal

health, and follow best practices, including those set out by WHO.²¹ Linkages between sexual and reproductive health and related policies, including education and nutritional policy, should be drawn explicitly.

28. The national plan, and policies linked to it, must be based on an up-to-date situational analysis of women's sexual and reproductive health and rights, informed by suitably disaggregated data and trends, as well as vital registration. Human rights require an understanding of which population groups are deprived of access, and determining the reasons behind that deprivation at both the national and subnational levels. Disaggregation of data according to the criteria of sex, age, urban/rural residence, ethnicity, marital status, HIV status, number of children, as well as by education, wealth quintile and geographic region, is critical in this regard.²²

29. A situational analysis should identify duty-bearers and assess institutional capacities and needs in terms of human, financial and other resources, in both public and private sectors. Such an analysis will thus assist in the identification of accountability gaps in sexual and reproductive health, and help to ensure adequate funding and staffing of facilities, awareness-raising and training, including regarding human rights, and the potential need to establish or to strengthen accountability mechanisms.

30. A situational analysis should include a broadly participatory review of the legal framework and the enactment, modification or rescission of laws, policies, regulations and guidelines, as required. Express legal recognition of sexual and reproductive health rights, equality between men and women and health as a human right should be accompanied by regulations providing for women's access to services.²³ Laws and policies that impede access to sexual and reproductive health services must

be changed, including laws criminalizing certain services only needed by women; laws and policies allowing conscientious objection of a provider to hinder women's access to a full range of services; and laws imposing third-party authorization for access to services by women and girls.

31. Under international law, a State is obligated to adopt appropriate measures;²⁴ appropriate measures are evidence-based measures. All measures should be based on authoritative public health guidance, including international guidelines, that reflect the highest level of evidence available and are updated regularly as new evidence emerges.²⁵ Although the State enjoys a margin of appreciation in realizing rights, the Government must be able to justify publicly policy choices and priorities, and the basis on which they have been made.²⁶

32. Essential interventions, services and medicines must be defined in accordance with core obligations under international law and consistent with the best available evidence.²⁷ The State may consider additional interventions, services, commodities and medicines across the reproductive continuum of care to be "essential" within its jurisdiction insofar as they supplement, rather than displace, those established as priorities according to the best public health evidence. As evidence evolves, the national plan should be updated accordingly.

33. Authoritative public health guidelines include the following interventions – to which universal access should be effectively ensured in the national plan – as essential for improving maternal health: family planning services; prevention and management of sexually transmitted infections, including HIV;

21 WHO, *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*, Geneva, 2004, p. 59.

22 WHO, *Keeping Promises, Measuring Results* (see footnote 5), p. 12.

23 WHO, *Reproductive health strategy* (see footnote 21).

24 *Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 4.*

25 *Partnership for Maternal, Newborn and Child Health, A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health*, Geneva, 2011; WHO, *Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health*, Geneva, 2010.

26 *Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 4; see also E/C.12/2000/4, para. 53.*

27 WHO, *Packages of Interventions* (see footnote 25).

management of unintended pregnancies, including access to safe abortion services, wherever legal, and post-abortion care; appropriate antenatal care; detection of domestic violence; management of pre-labour rupture of membranes and preterm labour; induction of labour for prolonged pregnancy; prevention and management of post-partum haemorrhage; caesarean sections; and appropriate post-partum care.²⁸ Best practices indicate that newborn care should be provided along with delivery and post-partum care for women.

34. Authoritative public health evidence indicates that the following medicines – to which universal access should be effectively ensured in the national plan – are essential for improving maternal health; oxytocics; antibiotics; misoprostol and mifepristone; magnesium sulphate; anti-retroviral medications and testing kits; anti-malarial medications in many countries and a full range of contraceptive methods, including condoms, hormonal methods and intrauterine devices.²⁹

35. The national plan should explicitly include additional actions necessary to enable women to effectively enjoy their sexual and reproductive health, including but not limited to their entitlements to these interventions and medicines.³⁰ For example, it should address improved access for adolescents to comprehensive sexuality education, sexual and reproductive health information and care, including family planning.³¹ It should also address the elimination of discriminatory laws and policies and harmful practices that present indirect and direct barriers to the use of such essential services by

women and to the effective enjoyment of their sexual and reproductive health rights.

36. Before finalization, the key elements of the national plan must be assessed for their likely impact on the maternal health of different population groups and income quintiles. Such ex ante impact assessment should particularly consider the impact on vulnerable and excluded populations, including but not limited to women with disabilities, racial and ethnic minorities, conflict-affected and displaced women, adolescents and other marginalized groups, according to national context.

37. A rights-based approach to health is a holistic and integrated approach to health systems. The national plan should recognize that the effective provision of emergency obstetric care and the prevention and treatment of sexually transmitted infections requires both the integration of services and well-functioning referral systems, including adequate communications and transportation and a continuum of care from home to hospital and across stages of a woman's interaction with the health system.³²

38. Explicitly considering the requirements of availability, accessibility, acceptability and quality under international law will help to ensure that planning addresses appropriately each component of the health system: service delivery, health workforce, information, medical products, vaccines and technologies, financing, leadership and governance.

39. 39. The national plan should specify capacity-strengthening measures for the health workforce and requirements for the number and distribution of health workers while ensuring respect for health workers' rights, including their labour rights. Where the conditions of work for health workers are a concern, the plan should specify measures to improve them.

40. The national plan should set out deliberate steps to realize universal access to sexual and reproductive

28 *Partnership for Maternal, Newborn and Child Health, A Global Review* (see footnote 25).

29 PATH, WHO and the United Nations Population Fund (UNFPA), "Essential medicines for reproductive health: guiding principles for their inclusion on national medicines lists", 2006.

30 WHO, *Packages of Interventions* (see footnote 25).

31 United Nations Educational, Scientific and Cultural Organization, *International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators*, December 2009. See also Commission on the Status of Women resolution 56/3, para. 9.

32 E/CN.4/2000/4, para. 44; Committee on the Elimination of Discrimination against Women, general recommendation No. 12.

health services, in terms of financing, population coverage and service expansion.

41. The national plan should address disparities in the substantive enjoyment of sexual and reproductive health rights based on prohibited grounds of discrimination, as well as inequalities in wealth, level of education or area of residence.³³

42. Remedying de facto discrimination in access to sexual and reproductive health services may require special measures to ensure equitable spending and distribution of health facilities, goods and services, including where absolute population numbers or cost effectiveness data would not ordinarily warrant such action. Such special measures are not construed as discrimination under human rights law.³⁴

43. The national plan should be devised and its implementation reviewed in consultation with the populations affected. The criteria and evidence for prioritizing must be transparent and subject to public scrutiny. Power differentials based on literacy, language, social status or other factors, which may exclude the women and girls most affected by the decisions taken, should be redressed to promote their meaningful participation.

B. BUDGETING

44. The identification of budgetary needs requires the involvement of a range of ministries and departments; for example, adolescent pregnancy must be addressed in conjunction with the Ministry of Education and will require adequate budgets for both health and education sectors.

45. The State must devote the maximum available resources to sexual and reproductive health. The establishment and sustainability of an adequate fiscal envelope to afford the maximum available resources is critical to a rights-based approach; where structural imbalances exist between expenditures

and revenues, strengthened and rationalized revenue collection should be undertaken before cuts are made to critical health areas, including sexual and reproductive health.

46. The budget should ensure that financing is not borne disproportionately by the poor. Out-of-pocket costs cannot impede accessibility of care, irrespective of whether services are provided by public or private facilities.³⁵

47. Addressing maternal health as a human rights issue in budget formulation confers added protection for resources allocated to related programmes at both the national and subnational levels:

- (a) If the overall available budget increases, resources for maternal health should increase accordingly insofar as significant need in that area remains. In particular in the case of high-burden countries, the principle of progressive realization under human rights law means that the budget for maternal health programmes would be expected to increase unless there is public justification to the contrary;
- (b) "Maximum available resources" under international law include resources from international assistance and cooperation;³⁶ however, increased resources from external sources should not replace governmental funding of sexual and reproductive health programming unless publicly justified and based on an impact assessment;
- (c) If the overall budget of the State decreases, resources for sexual and reproductive health programmes should not be decreased unless the Government demonstrates that it has taken all reasonable measures to avoid such reductions;
- (d) As reducing budgets for programmes directed at low-income and marginalized women may

33 E/CN.4/2000/4, para. 19.

34 *Convention on the Elimination of All Forms of Discrimination against Women*, art. 4; *International Convention on the Elimination of All Forms of Racial Discrimination*, art. 1; *Convention on the Rights of Persons with Disabilities*, art. 5.

35 E/CN.4/2000/4, para. 12; WHO, *World Health Report 2010: Health Systems Financing: the Path to Universal Coverage* (Geneva, 2010).

36 E/C.12/2007/1, para. 5.

constitute retrogression under international law, Governments bear a special burden in demonstrating the need for such cuts.

48. Both national and subnational governments should establish participatory processes, such as public hearings, during budget formulation. Citizens, civil society organizations, academics and health service providers should be able to contribute meaningfully to budgeting discussions, including by identifying needs, and be aware of decision-making criteria.

49. Budgets earmarked for sexual and reproductive health should not be reassigned, diverted or underspent during the fiscal year. In decentralized health systems, budgets should be allocated and funds distributed to the regions and districts in a timely and equitable manner.

50. In order to implement budgets effectively and ensure that they are properly spent, annual work plans that clearly allocate responsibilities at all levels of government should be used.

51. The human rights principles of transparency and accountability call for both allocated and spent budgets on sexual and reproductive health to be disaggregated by functional and programmatic classifications and on the basis of regional reporting. Sexual and reproductive health spending should be clearly identifiable in the overall budget and available in a format readily accessible to the general public.

52. Budgets should include provisions for ensuring effective accountability, including monitoring, access to justice for the poor, and both judicial and non-judicial accountability mechanisms to facilitate timely redress.

IV. Ensuring implementation in practice

53. Despite elaborate national planning and policies, a failure to respect, protect and fulfil women's rights to maternal health is often observed or becomes evident in implementation. Identifying an obstruction to effective implementation requires periodic, bottom-up, local diagnostic exercises to ascertain and provide feedback on what is happening to whom and where; why it is happening (what factors are preventing women, or certain women, from safely experiencing pregnancy and childbirth and enjoying their sexual and reproductive health rights more broadly?); who or what institution is responsible for such factors, and for addressing the problem; and how action should be taken (what do different duty-bearers need to do to address each factor?).

54. Human rights accountability requires follow-up on diagnosed problems and proposed remedial responses by the duty-bearers identified. Appropriate channels must therefore be available at the facility, district, regional and national levels, and across sectors and branches of government, for reviewing findings and taking appropriate action to address identified problems.

55. The two examples in the section below are merely illustrative. The effective application of a rights-based approach requires a contextualized understanding of the particular issues and challenges, including the availability, accessibility, acceptability and quality of goods, services and facilities, as well as of the underlying causes of maternal mortality and morbidity.

A. EXAMPLE OF IDENTIFIED PROBLEM: WOMEN ARRIVING LATE OR FAILING TO SEEK EMERGENCY OBSTETRIC CARE

56. The first step is to analyse the cause of delays and failure to seek care. A human rights-based approach places responsibility on the State for ensuring available, accessible, acceptable and quality facilities, goods and services to address life-threatening delays. Delays in the decision to seek care or opting out of the health system entirely are treated not as idiosyncratic, personal choices or

immutable cultural preferences but as human rights failures. They are affected by the inequitable and sometimes discriminatory distribution of health-care facilities, goods and services that makes emergency obstetric care both unavailable and physically inaccessible, as well as by a lack of awareness of the emergency signs among family and community members and the lack of empowerment of women to make decisions about their own well-being. Delays in arrival can also be attributable to out-of-pocket costs, lack of transportation or communications, and/or poor infrastructure. Lack of cultural sensitivity and acceptability of care at facilities, including language and provision for traditional birthing customs, also leads to a reluctance to seek care. If abortion laws are overly restrictive, responses by providers, police and other actors can discourage care-seeking behaviour. Lastly, when the population perceives that care quality is poor – even if not directly related to sexual and reproductive health – including lack of respectful treatment at facilities, it also affects decisions to seek care and undermines the health system as a core social institution.

57. The second step is to identify responsibility for each specific factor leading to delays or failure to seek care. For example, if a lack of a constant supply of medication or supplies is identified as undermining quality of care and generating distrust in the health system, it may be attributable to a variety of causes, including lack of adequate record-keeping at the facility, regional and/or national level that does not permit allocation formulas for inputs to reflect actual needs; a lack of local warehousing to ensure stockpiles of medications at the district and/or regional level; a flawed national procurement process not permitting equitable or timely distribution of quality medicines; corruption at any level; illicit or unscrupulous pricing practices by private manufacturers; or a combination of the above. These issues are not just technical ones; they affect the effective enjoyment of women's sexual and reproductive health rights.

58. The third step is to suggest and prioritize actions by different duty-bearers required for each factor causing the problem. For example, if the national procurement process for medicines is flawed, the Ministry of Health may need to examine procedures followed to award contracts and for quality control; and ineffective or ideologically-

based policies regarding the selection of medicines, including contraception. In addition, budgets may need to be modified by the Ministry, together with other ministries, to meet actual needs and address pre-existing disparities or exclusion of certain subpopulations; institutional oversight may need to be strengthened at the facility, district, regional and national levels to promote robust quantification of needs and reduce corruption; funding may need to be secured from donors to integrate information technologies into the health system; or a combination of the above.

B. EXAMPLE OF IDENTIFIED PROBLEM: ADOLESCENT GIRLS ARE SUFFERING FROM DISPROPORTIONATELY HIGH RATES OF MATERNAL MORBIDITY AND DEATH

59. The first step is to analyse not only why adolescent girls suffer from high rates of maternal morbidity and death, but also why they are becoming pregnant. A human rights-based approach defines the problem and addresses it in terms of both the immediate and underlying causes of maternal mortality and morbidity, given that they determine the possibilities for resolving concrete problems at the local level. Amidst many other factors, adolescent pregnancy might be due to a lack of comprehensive sexuality education; gender norms that reinforce early pregnancy; early marriage; high levels of sexual violence and/or transactional sex; a lack of youth-friendly health services; lack of affordable and accessible contraception; or a combination of the above. Disproportionately high rates of morbidity and death may be attributable to, inter alia, late arrival at health facilities or failure to seek care for any of the reasons noted in the example above. Among adolescents, there might also be a disproportionately high rate of self-induced abortion and fear of criminal sanctions; a marked lack of awareness relating to obstetric alarm signals; perceived and actual insensitivity to youth in facilities; or a combination of the above.

60. The second step is to identify responsibility for each factor, which may transcend the health sector. For example, if gender norms reinforce early pregnancy, there may be lack of awareness of girls' rights to education and equality among family members and of the health risks of pregnancy for

young adolescents; lack of positive leadership by community elders, local teachers and political leaders regarding gender roles; lack of education regarding women's rights and gender equality in national school curricula, coupled with forced pregnancy testing in schools or other policies that reinforce gender norms; national legislation that directly discriminates against women and girls or has a disproportionate adverse impact on them; economic pressures that contribute to early marriage and pregnancy; or a combination of the above.

61. The third step is to suggest and prioritize actions by different duty-bearers required for each factor causing the problem. For example, national legislation that directly discriminates against women and girls or has a disproportionate adverse impact on them, including in relation to age of marriage, education, land title and inheritance, or employment, in addition to health, should be modified. Legislation, policies and regulations directly affecting the health sector, including overly restrictive criminalization of services used by women, third-party authorization or unregulated conscientious objection, should be modified, and newly established obligations of providers and rights of individual users should be disseminated. Among other things, the national Government should undertake media and other awareness-raising campaigns targeted at adolescents, adults and disadvantaged groups, as well as at key stakeholders, such as community leaders and school teachers, to disseminate messages promoting gender equality and changes in legislation that may require funding from external donors in addition to cooperation with civil society.

62. The more specific the identification of the problem and the reasons for it, the more likely it is that duty-bearers may be held effectively responsible; this can only be done effectively at the local level.

63. The deliberation process itself is critical to understanding the complexities of addressing maternal mortality and morbidity and the responsibilities of duty-bearers, as well as to developing effective and sustainable solutions that are legitimate to the public. Local diagnoses will be conducted by an array of actors in contextually contingent ways, and not all of them will involve all stakeholders. Nevertheless, the meaningful participation of affected communities is

essential, in particular of women from marginalized and vulnerable groups and health workers, in efforts to identify problems, causes and duty-bearers, and in prioritizing remedial actions and solutions.

64. Evaluating factors that may constitute obstacles in practice requires examining sequencing and coordination within and between systems, including the appropriate alignment of:

- (a) Laws and policies (for example, ensuring appropriate protocols are issued and disseminated by the Ministry of Health to provide for abortion where it is legal);
- (b) Policies and budgets (for example, shifting budget allocations toward the needs of the poorest quintiles and/or marginalized groups);
- (c) Budgets and programmes (for example, ensuring that costs do not raise barriers to access to essential sexual and reproductive health care);
- (d) Policies and programmes (for example, ensuring that all levels of providers are actually performing functions set out in national and regional policies);
- (e) Training and programmes (for example, ensuring that sufficient numbers of mid-level providers are recruited and trained to meet the sexual and reproductive health needs of the population).

65. A rights-based approach requires simultaneous attention to immediate health interventions and the longer-term social transformation required to reduce maternal mortality and morbidity. Overcoming identified obstacles to all essential interventions, supplies and medicines within the context of health system strengthening must be prioritized. At the same time, however, efforts are also required to address any broader patterns of discrimination against women and/or particular groups of women that affect maternal mortality and morbidity.

66. Full respect for the rights of both health system users and health workers is fundamental to a rights-based approach. Any form of abuse, neglect

or disrespect of health system users undermines their rights. Institutions need to be organized and managed to facilitate respect for women's sexual and reproductive health rights, such as provision for privacy and confidentiality. Systematic education is required for policymakers, planners, health system administrators and providers to ensure that women's access to care is treated as a right and that all duty-bearers understand their corresponding obligations of conduct. Moreover, in a health system, health workers are rights-holders as much as duty-bearers. Ensuring adequate working conditions and treatment of health workers, including salary and benefits, disciplinary processes and voice, is necessary to respect their rights and, in turn, to promote health system effectiveness in addressing maternal mortality and morbidity.

V. Accountability

67. As has been stressed throughout the present report, accountability is central to every stage of a human rights-based approach. It requires not just transparency but meaningful participation by affected populations and civil society groups. Effective accountability also requires individuals, families and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to sexual and reproductive health and are empowered to make claims grounded in them.

68. In the sections above, emphasis was put on the importance of assessing accountability gaps within and beyond the health sector in the situational analysis and addressing them through planning and budgeting, as well as regular, ground-up diagnostic exercises and follow-up, in order to ensure implementation in practice. Monitoring, the dimensions of review and oversight, and remedies are also critical elements of the circle of accountability, as is establishing donor accountability.³⁷

A. MONITORING

69. Monitoring in a human rights framework requires the use of indicators, not all of which are quantitative or relate to the health sector.³⁸ A rights-based approach requires systematically tracking and evaluating:

- (a) Changes in structural factors over time; this includes, but is not limited to, examining whether adopted laws explicitly recognize sexual and reproductive health rights; adopting a national plan; and modifying laws that discriminate against women, as well as institutions, such as creating a national human rights institution;
- (b) Policy and budgetary efforts within and beyond the health sector. Policy efforts include, for example, costing, resourcing and implementation measures with regard to the national plan. Resources and expenditures relating to sexual and reproductive health should also be tracked, as should the capacity to relate spending to human rights goals and commitments, such as the elimination of financial barriers to care;
- (c) Concrete results in terms of women's sexual and reproductive health, and maternal mortality and morbidity in particular; this includes outputs, outcomes and impact in health system categories, ranging from availability, accessibility, acceptability and quality (both through objective indicators, such as case fatality rates, and subjective measures of women's satisfaction) of health facilities, goods and services to ultimate effects, such as fertility and adolescent birth rates and maternal mortality ratios.³⁹

70. Effective monitoring requires functioning health information systems, civil registration systems and disaggregated data. The disaggregation of information on the basis of sex, age, urban/rural

³⁷ WHO, *Keeping Promises, Measuring Results* (see footnote 5), p. 8.

³⁸ See HRI/MC/2008/3.

³⁹ *The Accountability Commission endorsed 11 indicators to promote enhanced accountability for maternal and child mortality and morbidity. WHO, Keeping Promises, Measuring Results* (see footnote 5), p. 13.

residence and ethnicity, as well as of education, wealth quintile and geographic region insofar as possible, is essential for ensuring non-discrimination and equity, and affording due protection to vulnerable and marginalized groups.⁴⁰

71. Quantitative indicators should facilitate the drawing of conclusions with regard to compliance with international obligations relating to sexual and reproductive health rights.⁴¹ In addition to disaggregation, as stated above, quantitative indicators should be (a) continuously or frequently measurable in order that the actions taken by an administration may be measured in a timely manner; (b) objective, to permit comparison across time and countries and/or subregions; (c) programmatically relevant, to enable priority setting and identification of accountability gaps; and, ideally, (d) subject to local audit to promote accountability to populations served. Not all maternal health indicators currently used at the national and international levels comply with such criteria; however, both Governments and development partners should foster accountability by ensuring that as many of the criteria as possible are met, including data objectivity (as in measures of skilled birth attendance).

72. Monitoring should facilitate the strengthening of the health system, including of the health information system. Emergency obstetric care is a core obligation under international law, and is the core maternal health intervention that depends most on a functioning, coordinated health system. Broader collection of information on the availability and use of emergency obstetric care, which depends on health facility survey data, can strengthen health information systems.⁴² Health information systems should also address biases in current demographic

and health data, which may affect vulnerable and marginalized groups, such as by excluding floating and migrant populations and women who do not have live births.

73. Monitoring should encompass non-State actors, including, but not limited to, pharmaceutical, commodities and device manufacturers, insurance companies and private service providers.

B. FORMS OF REVIEW AND OVERSIGHT

74. Human rights accountability requires multiple forms of review and oversight, including:

- (a) Administrative accountability with regard to sexual and reproductive health calls for internal rules and norms in health facilities and within the Ministry of health, which set standards for conduct and make subordinates accountable to superiors, to be monitored by a person or committee with no conflicts of interest;
- (b) Social accountability calls for civil society and public participation at all levels of decision-making regarding sexual and reproductive health, and throughout the project cycle. Community-based oversight of facility staff, finances and quality of care at facilities, such as “community scorecards”, “community-based local administration” of health facilities and accompaniment of women by family and community members can all contribute to social accountability and should be implemented according to context;
- (c) Political accountability calls for both national and subnational Governments to be able to justify to legislators the criteria used and decisions taken regarding sexual and reproductive health. For legislative oversight to be meaningful, the Executive should transparently share budget and planning documents, as well as results, and provide adequate time and information for meaningful deliberation by parliamentarians and local legislatures;
- (d) National legal accountability includes the duty of the State to guarantee effective enjoyment of human rights, including the duty to provide

40 *Ibid.*, pp.12-13.

41 Alicia Ely Yamin and Kathryn L Falb. “Counting what we know; knowing what to count: Sexual and reproductive rights, maternal health, and the Millennium Development Goals”, *Nordic Journal of Human Rights* (on file with the secretariat).

42 WHO, UNFPA, the United Nations Children’s Fund (UNICEF) and the Averting Maternal Death and Disability Programme, *Monitoring Emergency Obstetric Care (2009)*; see also WHO, *World Health Report 2005: Make Every Mother and Child Count* (Geneva, 2005).

effective legal remedies to victims.⁴³ Legal remedies can be judicial and non-judicial, such as by through a national human rights institution;⁴⁴

- (e) International accountability calls for the systematic integration of information on efforts to prevent and reduce maternal mortality and morbidity into reports submitted to international human rights mechanisms, including regional human rights bodies, treaty monitoring bodies and for the universal periodic review of the Human Rights Council, together with implementation of recommendations thereof.

75. A human rights-based approach depends on fostering accountability of multiple actors and at various levels, within and beyond the health sector, including, but not limited to:

- (a) Professional accountability. Although front-line health workers must not be treated as scapegoats for institutional failures, effective standards should be in place to ensure quality of care, and sanctions by professional associations, medical councils and/or licensing bodies should be applied in the event of proven negligence, abuse or malpractice, irrespective of whether providers are tenured;
- (b) Institutional accountability. Accountability at the facility level requires continuous oversight and regular follow-up with regard to any gaps identified. Complaint procedures should be instituted in all facilities for health system users, including appeal procedures for decisions by institutional management or ethics committees denying access to any form of sexual and reproductive health care. Furthermore, internal ombudsperson procedures should be instituted for review of health workers' complaints in each facility, with possibility for appeal;

- (c) Health system accountability. In addition to continuous systemic monitoring and regular diagnostics of obstacles, reviews of all maternal deaths should be conducted routinely in order that lessons may be learned at all levels of the health system:- from individuals' behaviour and practices to national policies, and along the continuum of care from home to hospital. Maternal death reviews should be conducted in the spirit of shared responsibility rather than attributing blame, and to inform actions to prevent future maternal deaths;

- (d) Private actor accountability. Corporate enterprises and other non-State actors have a responsibility to respect women's sexual and reproductive health rights, which means that they should act with "due diligence" or appropriate care to avoid interfering with such human rights.⁴⁵ In turn, appropriate laws, policies, regulations and guidelines should be established and enforced by the State with regard to such infringements;

- (e) Donor accountability. Donors have obligations of international assistance and cooperation with regard to sexual and reproductive health rights, including both financial and non-financial obligations, as described below.

C. REMEDIES

76. Remedies are essential to give effect to rights. They may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.⁴⁶ Remedies may be administrative, but appeal to judicial review from administrative proceedings will often be appropriate.⁴⁷ Remedies may also be provided through a national human rights institution. In all cases, remedies should be accessible, affordable, timely and effective, which will require adequate funding, capacity and mandates.

43 *Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 5.*

44 *See for example Kenya National Commission on Human Rights, "Realizing sexual and reproductive health rights in Kenya: a myth or reality?", 2012, available from www.knchr.org/reproductivehealth.aspx.*

45 *See A/HRC/17/31.*

46 *E/C.12/2000/4, para. 59.*

47 *E/C.12/1998/24, para. 9.*

77. Judicial remedies have a key role to play in relation to sexual and reproductive health rights, including:

- (a) Ensuring the implementation of existing laws and policies;
- (b) Reforming laws, policies and budgets that do not adequately protect sexual and reproductive health rights;
- (c) Challenging discriminatory barriers to sexual and reproductive health care;
- (d) Providing redress for violations of sexual and reproductive health rights in practice.

78. National human rights institutions should also promote accountability with regard to sexual and reproductive health rights by, *inter alia*, investigating violations of women's sexual and reproductive health rights; monitoring implementation of legislation, performance of selected institutions, court judgements and recommendations made by international human rights bodies; and organizing public hearings and education campaigns about maternal mortality and morbidity and human rights.

79. To ensure the effective use of remedies, the State must systematically raise awareness about the applicability of claims relating to women's sexual and reproductive health rights among lawyers, judges and the public, and provide adequate funding for accountability mechanisms.

80. Systems of effective recourse depend on parliamentarians supporting improved accountability for violations of women's sexual and reproductive health rights, including by addressing physical, economic and other barriers to recourse systems, especially for vulnerable or marginal groups; lack of timely relief; lack of awareness of remedies; inadequacy of existing causes of action to secure redress; and deficiencies in funding, mandate, independence or competencies of national human rights institutions.

VI. International assistance and cooperation

81. All development partners should contribute to the creation of a social and international order in which human rights, including women's sexual and reproductive health rights, may be realized.⁴⁸ Human rights obligations with regard to advancing global health, including sexual and reproductive health, call for shared approaches and systems of collective responsibility together with a global development agenda that centrally reflects issues of social and environmental sustainability, equality and respect, and the fulfilment of human rights. Underlying issues concerning maternal mortality and morbidity, such as gender equality and sustaining effective and an equitable health system, are challenges faced in countries of all income levels.

82. Obligations of international assistance and cooperation require States in a position to assist to do so. They require States that can demonstrate their lack of available resources to meet their human rights obligations to stem resource loss, both financial and human, and to seek international cooperation.⁴⁹

83. There is increasing recognition of the responsibilities of non-State development partners to ensure that human rights are not violated through their activities.⁵⁰

84. Obligations to provide international assistance and cooperation supplement but do not displace obligations of national Governments.

85. All development partners should ensure that their development policies are rights-based, which includes refraining from doing harm to women's sexual and reproductive health. For example, restrictions in aid, such as on information regarding

48 *Universal Declaration of Human Rights, art. 28. See also the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) of the Organization for Economic Cooperation and Development (OECD) (available from www.oecd.org/dataoecd/30/63/43911948.pdf), para. 13 (c).*

49 *International Covenant on Economic, Social and Cultural Rights, art. 2.*

50 *See A/HRC/17/31.*

critical reproductive services or intellectual property regimes that create barriers to accessing essential medicines interfere with Governments' abilities to realize women's sexual and reproductive health rights.⁵¹

86. International cooperation should be aimed at strengthening the capacity of national health systems to advance women's sexual and reproductive health rights. Development partners should refrain from creating a parallel administration to that of the Ministry of Health and/or utilizing systems other than those of the Government.

87. Donor States should protect women's sexual and reproductive health rights by effectively regulating private actors over which they exercise control.⁵² These include pharmaceutical companies, commodities and device manufacturers, and other companies that affect the delivery of sexual and reproductive health services abroad.

88. Policy coherence is essential to the global partnership for development. For example, donor States should not invest in strengthening health systems while drawing away, or allow private actors in their jurisdictions to draw away, human resources from them through migration policies.⁵³ Donor States, individually and collectively, should also evaluate trade, economic, fiscal and debt policies for coherence with the advancement of women's sexual and reproductive health rights.

89. Development partners should ensure predictable, harmonized and transparent economic assistance.⁵⁴ Agreement should be reached with national Governments on consolidated budget

support as well as reporting of "externally funded expenditures".⁵⁵ The Creditor Reporting System of the OECD Development Assistance Committee should be improved to capture, in a timely manner, all sexual and reproductive health spending by development partners,⁵⁶ which should be publicly available and disseminated in accessible formats.

90. The design, implementation and evaluation of all aspects of international assistance and cooperation should ensure the participation of civil society and the intended beneficiaries of programmes. Development partners should make their programme evaluations public and report regularly, in accessible formats, to civil society groups, national parliaments and other national and United Nations oversight bodies.

51 E/C.12/1997/8, para. 4; E/C.12/2000/4, para. 41.

52 E/C.12/2000/4, para. 39; A/60/348, para. 62.

53 *Ibid.*, para 61. See also the WHO Global Code of Practice on the International Recruitment of Health Personnel, 2010. Available from www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf.

54 OECD, *the Paris Agreement and Accra Agenda* (see footnote 48). See also the *Busan Partnership for Effective Development Cooperation, outcome of the Fourth High-level Forum on Aid Effectiveness, 2011*. Available from www.aideffectiveness.org/busanhlf4/images/stories/hlf4/OUTCOME_DOCUMENT_-_FINAL_EN.pdf.

55 WHO, *Keeping Promises, Measuring Results* (see footnote 5), p. 2.

56 *Ibid.*, recommendation 9.



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Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance

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