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Actions to strengthen linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all of their human rights and elimination of preventable maternal mortality and morbidity

Report of the Secretary-General

Summary

Pursuant to Commission on the Status of Women resolution 54/5, the present report summarizes actions taken to address maternal mortality, with particular attention to efforts directed towards strengthening linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all their human rights, and elimination of preventable maternal mortality and morbidity. The report, based on contributions from 13 United Nations entities, 18 Member States and academic researchers, finds that, despite strengthening of the normative framework for confronting maternal mortality as a human rights issue having gender inequality and discrimination as root causes, a sustained and coordinated effort to address those factors has yet to emerge.

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I. Background

1. At its fifty-fourth session in 2010, the Commission on the Status of Women adopted resolution 54/5, entitled “Eliminating maternal mortality and morbidity through the empowerment of women” (see E/2010/27 and Corr.1, chap. I.D). In that resolution, the Commission, inter alia, requested the Secretary-General to provide a report to the Commission at its fifty-sixth session in 2012, in consultation with Member States, international organizations and all other relevant stakeholders, taking into account Human Rights Council resolution 11/8 of 17 June 2009 and other relevant United Nations resolutions, on actions to strengthen linkages among programmes, initiatives and activities throughout the United Nations system for gender equality, the empowerment of women and girls, protection of all of their human rights and elimination of preventable maternal mortality and morbidity. The present report responds to that request.

2. The report summarizes initiatives and actions taken by Member States, the United Nations system and civil society organizations to eliminate preventable maternal mortality and morbidity and offers recommendations for further action.

II. Persistence of maternal mortality[1] and morbidity

3. Some 342,000 to 358,000 maternal deaths occurred globally in 2008.[2] The global maternal mortality ratio, or the number of maternal deaths that occur for every 100,000 live births, was 260 in 2008, having declined from 400 in 1990. For developing regions in 2008, the ratio was 290 maternal deaths per 100,000, while in more developed regions, it was only 14 per 100,000.

4. Developing regions varied considerably in maternal mortality levels, with sub-Saharan Africa having the highest maternal mortality ratio, 640 maternal deaths per 100,000 live births, a figure that was well above twice the global average. Among individual countries, four (Afghanistan, Chad, Guinea-Bissau and Somalia) had maternal mortality ratios over 1,000 per 100,000 live births.

5. In terms of trends, the picture is equally mixed (see table). Since 1990, maternal mortality has declined in almost all regions.[3] There have been large declines (greater than 50 per cent) in South Asia, East Asia and the Pacific, and Central and Eastern Europe/Commonwealth of Independent States. Despite a declining trend, the average annual percentage decline in the global maternal mortality ratio of 2.3 per cent per year over the period 1990-2008 falls short of the

[1] The World Health Organization (WHO) defines maternal mortality as “the death of a woman while pregnant or within 42 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”.

[2] Separate estimates were prepared for 2008 by the United Nations Maternal Mortality Estimation Inter-Agency Group and by the Institute for Health Metrics and Evaluation, University of Washington, Seattle, Washington, United States of America. See Rafael Lozano and others, “Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis”, *Lancet*, vol. 378, No. 9797 (24 September 2011), pp. 1139-1165.

[3] The apparent increase in developed regions is insignificant, as the rate has fluctuated around a low level.

figure of 5.5 per cent required to achieve Millennium Development Goal 5, namely, a reduction in the maternal mortality ratio by 75 per cent between 1990 and 2015.

Trends in maternal mortality ratios, 1990-2008

	Estimated maternal mortality ratio[a]						
Region or country group	*1990*	*1995*	*2000*	*2005*	*2008*	*Percentage change between 1990 and 2008*	*Annual percentage change between 1990 and 2008*
Sub-Saharan Africa	870	850	790	710	640	-26	-1.7
Eastern and Southern Africa	750	760	720	630	550	-26	-1.7
West and Central Africa	980	940	870	780	720	-27	-1.7
Middle East and North Africa	270	230	200	180	170	-37	-2.6
South Asia	610	510	430	330	290	-53	-4.2
East Asia and the Pacific	200	160	130	100	88	-56	-4.5
Latin America and the Caribbean	140	130	110	91	85	-41	-2.9
Central and Eastern Europe/ Commonwealth of Independent States	69	60	48	36	34	-52	-4.0
Industrialized countries	12	10	11	14	14	16	0.8
Developing countries	440	410	370	320	290	-34	-2.3
Least developed countries	900	840	750	650	590	-35	-2.4
World	400	370	340	290	260	-34	-2.3

Source: Ann Paxton and Tessa Wardlaw, "Are we making progress in maternal mortality?", *New England Journal of Medicine*, vol. 364, No. 21 (26 May 2011), p. 1991.

[a] Number of maternal deaths per 100,000 live births.

6. The major direct causes of maternal mortality include haemorrhage, infection, high blood pressure, unsafe abortion and obstructed labour. Other important causes include malaria, anaemia and HIV/AIDS.[4] However, the root causes of maternal mortality and morbidity are human rights violations such as discrimination, gender-based violence, including female genital mutilation, and inadequate investment in and/or unequal access to education, basic health, nutrition and basic health care. Health systems are overburdened and constrained by a lack of investment and resources. Competing priorities and insufficient national resources often combine to push women's health out of the political agenda, thereby violating their rights.

7. These factors underlie the wide disparities in maternal mortality that exist across and within countries and regions and that are also evident across residential groups, including rural/urban populations, cultural and religious groups and various social and economic classes. Between wealthy and poor households, for example, wide differentials exist in respect of access to quality care. The widest gaps are in South Asia and sub-Saharan Africa, where the wealthiest women are, respectively, five and three times more likely than the poorest women to be attended by trained health-care workers at delivery. In developing regions as a whole, women in the

[4] See http://www.who.int/topics/maternal_health/en/index.html (accessed 20 December 2011).

richest households are three times as likely as women in the poorest households to receive professional care during childbirth.[5]

8. Several diseases work individually or interactively to predispose pregnant women to higher risks of mortality and morbidity. HIV, malaria and anaemia are particularly dangerous in pregnant women. Although its role is difficult to quantify, it is known that HIV/AIDS contributes to high maternal mortality in many contexts. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), maternal mortality would be 20 per cent lower were it not for HIV.[6] Worldwide, 60,000 pregnant women died in 2009 alone because of HIV.[7] Yet, nearly half of pregnant women living with HIV are not reached by critical services.[8] HIV and AIDS increase the risk of complications such as anaemia, post-partum haemorrhage and puerperal sepsis.[9] The harmfulness associated with gender norms, expectations, stereotypes and roles leaves many women and girls unable to exert control over their sexual and reproductive decision-making, rendering them vulnerable to HIV/AIDS and other sexually transmitted diseases. Pregnant women infected with HIV often have poor access to or inadequate quality of health care because of substantial stigma and discrimination from health-care workers and community members. This is particularly the case for adolescents.[10]

9. Malaria accounts for considerable mortality during pregnancy and often results in severe anaemia. The control of malaria is a major part of the World Health Organization (WHO) "Making Pregnancy Safer" initiative, which recommends intermittent preventive treatment for all pregnant women at risk of *Plasmodium falciparum* infection in sub-Saharan countries with stable malaria transmission.[11] Long-lasting insecticidal nets and indoor residual spraying are the top recommended interventions for reducing malaria transmission. Within households, the use of bednets may be strongly linked to culturally accepted sleeping patterns. Gender plays an important role, as limited supplies of bednets may be reserved for the male head of household.[12] Eliminating malaria infections among pregnant women saves lives of both mothers and infants.

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[5] *The Millennium Development Goals Report 2010* (United Nations United Nations publication, Sales No. E.10.I.7). Available from http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf (accessed 11 December 2011).

[6] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010* (Geneva, 2010).

[7] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015* (Geneva, 2011).

[8] World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Children's Fund (UNICEF), *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2010* (Geneva, WHO, 2010).

[9] James McIntyre, "Mothers infected with HIV: reducing maternal death and disability during pregnancy", *British Medical Bulletin*, vol. 67 (2003), pp. 127-135.

[10] Quarraisha Abdool-Karim and others, "HIV and maternal mortality: turning the tide", *Lancet*, vol. 375, No. 9730 (5 June 2010), pp. 1948-1949.

[11] See http://www.who.int/malaria/world_malaria_report_2011/9789241564403_eng.pdf (accessed 20 December 2011).

[12] See http://www.who.int/gender/documents/gender_health_malaria.pdf (accessed 20 December 2011).

III. Addressing the elimination of maternal mortality as a human rights issue

10. Although the need to improve women's status, educate communities, and strengthen and expand antenatal care, delivery care and post-partum care were clearly recognized at the Safe Motherhood Conference, held in Nairobi in 1987, this approach to programmes was not always taken up by key actors. Instead, many donors focused on health sector interventions to increase access to professional medical care.[13]

11. When the Programme of Action of the International Conference on Population and Development[14] defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity in all matters relating to the reproductive system and to its functions and processes",[15] it incorporated maternal morbidity and mortality into the discourse on human rights. This rights-based approach was echoed by the Beijing Platform for Action[16] adopted by the Fourth World Conference on Women in 1995.[16] The commitment to reduce maternal mortality was again reiterated in 2000 at the Millennium Summit at which the elimination of maternal mortality was established as Millennium Development Goal 5, with its targets of reducing the maternal mortality ratio by 75 per cent between 1990 and 2015 and achieving universal access to reproductive health by 2015.

12. Human Rights Council resolution 11/8, entitled "Preventable maternal mortality and morbidity and human rights",[17] and resolution 15/17, entitled "Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8",[18] are particularly noteworthy for renewing the call, and deepening the normative basis, for addressing maternal mortality as a human rights issue. Resolution 11/8 affirmed that addressing maternal mortality and morbidity required the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health (para. 2); and resolution 15/17 encouraged States to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls (para. 7).

13. These recent resolutions have built on the normative foundation provided by the Convention on the Elimination of All Forms of Discrimination against

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[13] Ann M. Starr, "Safe motherhood initiative: 20 years and counting", *Lancet*, vol. 368, No. 9542 (30 September 2006), pp. 1130-1132.

[14] *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.

[15] Ibid., para. 7.2.

[16] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[17] See *Official Records of the General Assembly, Sixty-fourth Session, Supplement No. 53* (A/64/53), chap. III.A.

[18] Ibid., *Sixty-fifth Session, Supplement No. 53A* (A/65/53/Add.1), chap. II.

Women,[19] which in article 12 calls on States parties to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

14. It is important to recognize the role that civil society has played in catalysing the emergence of the strong human rights perspective on maternal mortality. During the 2007 Women Deliver Conference, civil society led the transition in discourse from a focus on providing services to one centred on developing a human rights approach.[20] Its engagement and advocacy fuelled the adoption of Human Rights Council resolution 11/8.

15. Family Care International, the Global Health Council, the International Initiative on Maternal Mortality and Human Rights, the Safe Motherhood Initiative, and Women Deliver have been engaged by civil society to actively draw attention to the need for a better understanding and improved knowledge of maternal health rights among health-care professionals and policymakers.

16. A joint project by the Center for Economic and Social Rights and the Instituto Centroamericano de Estudios Fiscales (Guatemala) is one of many examples reflecting civil society's influence on government efforts to bring a human rights perspective into policymaking on maternal health. This project resulted in the enactment of a national maternal health law.[21]

IV. Initiatives, programmes and activities for addressing maternal mortality and morbidity

17. As noted in the report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights (A/HRC/14/39), an exhaustive overview of all major existing global initiatives and activities to address preventable maternal mortality and morbidity would be overwhelming in terms of length (para. 45). The present section therefore presents a synopsis of activities, programmes and initiatives of Member States, the United Nations system and civil society.

18. The above-mentioned report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights and the report of the Office of the High Commissioner on practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity and human rights (A/HRC/18/27 and Corr.1 and Corr.1/Rev.1) provide a useful context within which to view initiatives and programmes designed to address maternal mortality since they elaborate on key issues identified in Human Rights Council resolutions 11/8 and 15/17. In particular, in paragraph 3 of document A/HRC/18/27, the Council noted that, with respect to a human rights approach to addressing maternal mortality, State obligations are underpinned by seven specific human rights principles: equality and

[19] United Nations, *Treaty Series*, vol. 1249, No. 20378.

[20] See http://www.womendeliver.org/conferences/2007-conference/ (accessed 20 December 2011).

[21] See Center for Economic and Social Rights, "Best practices in addressing maternal mortality from a human rights perspective: a framework for monitoring policies and resources for MMM prevention in Guatemala", p. 1.

non-discrimination, participation, empowerment, transparency, sustainability, international cooperation and accountability.

19. Further, in paragraph 5 of document A/HRC/18/27 five features common to a human rights approach to addressing maternal mortality and morbidity were identified:

(a) Broad social and legal changes to enhance women's status by promoting gender equality and eliminating harmful practices;

(b) Increasing access to contraception and family planning to enable women and adolescent girls to make decisions regarding their sexuality and fertility, including delaying and limiting childbearing and preventing sexually transmitted infections, including HIV/AIDS;

(c) Strengthening health systems and primary health care to improve access to, and use of, skilled birth attendants and emergency obstetric care for complication;

(d) Addressing unsafe abortion for women;

(e) Improving monitoring and evaluation of State obligations to ensure the accountability of all actors and to implement policies.

20. While some Member States contributing to this report have described initiatives that address several of these actions, many focused on initiatives and activities for strengthening health systems so as to improve access to care. There were fewer mentions of activities geared towards introducing the broad legal changes required to address the root causes of maternal mortality and morbidity. Initiatives designed to address unsafe abortion were rarely reported; and there was little to suggest monitoring of State obligations towards the accountability of all actors.

A. Initiatives of Member States

21. Austria's mother-and-child health programme assures medical care during pregnancy. Women undergo six clinical examinations. Since 2010, an additional ultrasound examination, and an HIV test, as well as an oral glucose test, have been added to the tests administered to pregnant women.

22. In Belgium, female genital mutilation is considered a fundamental violation of women's and girls' rights. Belgium has ratified a large number of international treaties that condemn reproductive rights violations, including female genital mutilation. The national plan of action 2010-2014 against partner and intra-familial violence also addresses female genital mutilation and lays out means of protecting and supporting migrant reproductive rights. Programmes are in place to educate service providers and migrants on their health and reproductive rights.

23. Chad promotes the reproductive health of women and girls. The right to health is recognized in article 37 of the Constitution. Female genital mutilation is condemned and measures are in place to protect those infected with HIV or living with AIDS. Chad has also adopted a road map to accelerate the reduction of maternal mortality.

24. The Congo focuses on controlling tuberculosis, ensuring the rights of those living with HIV/AIDS, and treating malaria among pregnant women. The National Plan for Development and Health (2007-2011) aims at strengthening the health system, reducing maternal mortality as well as morbidity, improving human resources in the health sector, and increasing community participation and partnership for health. Together with the United Nations Population Fund (UNFPA), WHO, the United Nations Children's Fund (UNICEF) and civil society organizations, the Congo launched in 2010 the campaign to accelerate the reduction of maternal mortality in Africa. The principal objective is to improve the availability and utilization of quality health services for women in order to reduce maternal mortality. Emphasis has also been placed on data-collection procedures so as to broaden the knowledge base and improve intervention strategies with regard to maternal mortality.

25. The Dominican Republic has launched several programmes designed to preserve the health of women and reduce maternal mortality. These programmes aim to provide better obstetric care for women and raise awareness on the causes of maternal mortality. There are also policies in place for reducing unwanted pregnancies, maternal mortality, violence and HIV/AIDS among women and adolescents. These strategies are empowering women to play an active role in health and reproductive care.

26. In Ecuador, Government efforts have focused on broadening the knowledge base encompassing causes of maternal mortality and morbidity and on providing better health services for women and girls so as to reduce HIV, sexually transmitted diseases, uterine cancer and intra-familial violence.

27. A new health-care act in Finland, in force since May 2011, obligates municipalities to organize maternity health services for all pregnant women and their families within the residential area. Services include follow-up and promotion of the health of pregnant women. Efforts are under way to expand professional and sectoral collaboration during pregnancy both in maternity hospitals and within post-natal services. The role of men and boys is increasingly taken into consideration and a sexual education programme is targeted at boys and fathers.

28. In New Zealand, maternity services are free, and all women have access, without discrimination, to a comprehensive range of free or low-cost health services, including all maternal services as well as sexual and reproductive health services, counselling and support against sexual and physical violence.

29. Portugal has invested in projects that have a gender-equality focus, especially in those related to domestic violence and its implications for women's physical and psychological health. The national health system ensures all citizens nearly free access to primary care centres and public hospitals. Pregnant women have access to health facilities and care, which may have contributed to the drop in maternal mortality from 19 to 3.8 per cent between 1980 and 2008. Access to family planning by women under age 18 has been allowed since 1984, the same year in which family planning appointments and contraception became free of charge in the National Health Service. Vaccination against human papillomavirus (HPV) was introduced in the national health vaccination plan for all girls up to age 13.

30. Denmark, Italy and Japan reported mainly on their assistance to other countries and programmes. Denmark supports a number of United Nations and

international organizations as well as non-governmental organizations that address maternal mortality. This includes support to UNFPA, WHO and International Planned Parenthood Federation and Family Care International. Denmark is also working with partners in support of developments in the area of midwifery, including the review and change of regulations and practices so as to empower mid-level providers who perform life-saving procedures. Denmark addresses sexual and reproductive health and rights through several bilateral health sector programmes.

31. Ensuring maternal health is a priority in Italy's health policy, especially with respect to assistance to other Member States. Italy supports efforts to ensure universal access to health care and effective and efficient health services across a number of countries. Since 2004, it has focused on female genital mutilation, providing more robust bilateral and multilateral financial assistance in order to reach women in need in African countries where the practice exists. Domestically, the Ministry of Health has issued recommendation No. 6/2008 for the management of clinical risk during labour and delivery. In December 2010, an agreement was signed on the guidelines for the promotion and improvement in the quality, safety and appropriateness of care delivery for childbirth and reduction in caesarean sections. This agreement addresses, among other issues, the high number of caesarean sections performed in Italy which could heighten the risk of maternal morbidity and mortality.

32. Japan supports a safe motherhood project in Bangladesh. The project aims to improve the health of mothers, pregnant women and newborn babies through strengthening capacities of health management and improving facility-based health services. The project, which also facilitates the creation of community support groups for mothers and pregnant women, recorded significant increases in the proportion of women accessing emergency obstetric care when they experienced complications during pregnancy and delivery.

33. Malaysia has identified various stages for a broad-based service approach to maternal mortality. Government agencies in collaboration with UNFPA, and civil society organizations, have made inroads in improving reproductive health. Workshops for obstetricians and paramedics on gender and rights and reproductive and maternal health have been conducted with a view to clarifying the rights-based and gender-sensitive approach to maternal health. Under the National Family Planning Programme, cafeteria-type services are provided to ensure that clients are offered a wide choice of safe, effective, affordable and acceptable methods of contraception at the 56 clinics located throughout the country. Mobile clinics are used to reach women in marginalized areas and the urban poor.

34. The Government of Namibia developed a road map to accelerate the reduction of maternal and child morbidity and mortality. The road map targets all women, including those at high risk during pregnancy, labour, delivery and post-partum. Efforts to strengthen health systems include capacity-building for health workers in the area of maternal, perinatal and neonatal death reviews. In addition, training has been offered to traditional birth attendants to facilitate the recognition of danger signs and enhance women's timely referral to health facilities.

35. In Saint Vincent and the Grenadines, maternal mortality is mainly due to obstetric complications such as eclampsia and obstetric trauma. Policies are in place to effectively manage services for prenatal, antenatal and post-natal clients at

district and central levels. Access to prenatal services is affordable and primary health care is free. In light of the relationship among education, health and economic empowerment, major strides have been made in eliminating the gender disparity in primary and secondary school education. Efforts to strengthen data and knowledge include regular presentation and discussion of perinatal and maternal health statistics, and the implementation of the national health information system.

36. Sweden recognizes the right of women to decide freely and responsibly in matters involving their own bodies. In July 2010, the Government adopted a new policy which highlights maternal health in the context of sexual and reproductive health and rights. Through the Swedish International Development Agency, special efforts are being made to support the achievement of Millennium Development Goal 5 through a broad sexual and reproductive health rights approach. Sweden also supports initiatives such as Reproductive Health Access, Information and Services in Emergencies (RAISE) designed to improve access to comprehensive reproductive health care, including the provision of emergency obstetric care, in conflict, post-conflict and crisis situations.

37. In the Syrian Arab Republic, it is estimated that in 2009, the proportion of births with professional assistance had risen to 96.2 per cent from 76.8 per cent in 1993. The numbers of women of reproductive age per obstetrician fell from 966 in 1993 to 666 in 2008. Given the evidence from various surveys that an improved economy, the eradication of poverty and increased levels of female education increase women's acceptance and utilization of available health services, the Syrian Arab Republic has invested in poverty eradication and empowerment of women, and prioritizes these goals in the tenth five-year plan (2005-2010). There is growing concern in Syrian society over issues related to violence against women. Efforts to confront this issue, in particular domestic violence, are being intensified.

38. Uruguay has placed emphasis on collecting sector-specific statistics on maternal mortality. The efforts to confront maternal mortality are in evidence in the work of Uruguay's 2006 National Commission for Reduction of Obstetric Morbidity which focuses on vigilance and data collection in its effort to reduce obstetric morbidity.

B. United Nations system initiatives

39. United Nations entities, by virtue of their diverse mandates, have implemented activities, programmes and initiatives encompassing a wider range of the elements of a human rights approach, as identified in paragraph 19. Initiatives have included awareness-raising, education and capacity-building (the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNFPA, UNICEF and WHO); promoting participation and leadership and addressing the social, cultural and economic determinants of maternal health (United Nations Development Programme (UNDP)); addressing HIV/AIDS (UNAIDS); and addressing the special needs of women in conflict and post-conflict settings (Office of the United Nations High Commissioner for Refugees (UNHCR)). Despite the broader focus, as with Member States, a strong medical care/service-provision orientation remains.

40. UNFPA has addressed the broad context of maternal mortality and morbidity by enhancing the awareness of girls' rights through its support of a project in Ethiopia that provides education to adolescent girls aimed at helping them delay

marriage. In 2008, it launched an Investing in Midwifery Programme with the International Confederation of Midwives as an entry point for the management of human resources for health (including training, recruitment, deployment, retention and supervision). The number of participants in this programme has been scaled up from 11 to some 30 countries in Africa, Asia and Latin America. National midwifery strategies have been drafted in Afghanistan, Bangladesh, the Sudan and Uganda. UNFPA has provided support to Governments in carrying out national emergency obstetric and newborn care needs assessments in over 20 countries.

41. Together with partners, UNFPA launched the global Campaign to End Fistula. It has helped over 20,000 women and girls to recover from fistula and rebuild their lives through access to surgical treatment and care, and provision of social reintegration services.

42. Aware that unplanned pregnancies and unsafe abortions are major causes of maternal mortality and morbidity, UNFPA, through its Global Programme on Reproductive Health Commodity Security, supports family planning programmes in countries with high unmet need for family planning and low contraceptive prevalence. It has provided support to 45 countries, thereby contributing to significant increases in the contraceptive prevalence rate in these countries.

43. UNDP has focused on building robust health systems through its work in strengthening governance, institutions and management capacity, as well as through its coordinating and convening role in bringing together multiple partners and resources at national and local levels. As part of its mandate to address cross-cutting gender-equality issues which influence all the Millennium Development Goals, UNDP works through three pillars: (a) promoting national leadership, sustainable financing, effective development assistance and aid coordination for maternal and reproductive health; (b) addressing the social, cultural and economic determinants of maternal and reproductive health; and (c) responding to governance, institutional and management capacity bottlenecks that impact on the health sector.

44. UNDP has been engaged at various levels. In Tunisia, it worked in collaboration with UNICEF and UNFPA to prepare the first Millennium Development Goal report, which was a critical advocacy tool for scaling up efforts to reduce maternal mortality. In Ghana, it promoted national leadership and sustainable financing for Millennium Development Goal 5 by supporting the strengthening and alignment of the second Growth and Poverty Reduction Strategy. In India, UNDP supports a creative public-private partnership to scale up LifeSpring Hospitals, a chain of small hospitals providing low-income women in India with access to maternal and child health services. In Kenya, it leads an inter-agency HIV initiative, Universal Access for Women and Girls Now!, to help the Government scale up comprehensive post-rape care services in health facilities. A programme is in place in Uganda to target bottlenecks and strengthen coordination of the Goal 5 response.

45. UNAIDS has worked towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths. The UNAIDS Strategy 2011-2015: Getting to Zero, which was adopted in December 2010, includes a goal to eliminate the vertical transmission of HIV and reduce AIDS-related maternal mortality by half, by 2015. The Strategy prioritizes gender equality and human rights as one of its three overall pillars for achieving universal

access to HIV prevention, treatment, care and support and the Millennium Development Goals.

46. The gender-equality component of the UNAIDS Strategy is being operationalized through the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV in collaboration with civil society in over 80 countries.[22] Women's and girls' access to HIV and sexual and reproductive health services is a key component of the Agenda on Women and Girls. UNAIDS, together with the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and co-sponsors, is providing support to Member States in promoting strategies for addressing gender-based violence and in engaging men and boys in HIV strategic plans of 14 countries.[23]

47. Together with UN-Women, UNAIDS organized a high-level consultation on sexual and reproductive health and rights of women and girls living with HIV during the fifty-fifth session of the Commission on the Status of Women in February 2011. The consultation shed light on the factors that deter women from accessing HIV, antenatal, and sexual and reproductive health services.

48. During the High-level Meeting on AIDS, held in June 2011, UNAIDS developed and launched the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015,[24] which provides the foundation for country-led action to eliminate vertical transmission and reduce maternal mortality in low- and middle-income countries. The UNAIDS platform "Treatment 2.0" will enable delivery systems to be further decentralized and integrated with other areas of health care such as maternal and child health and tuberculosis services.

49. Promoting education and literacy is at the heart of the work of UNESCO in support of the achievement of Millennium Development Goal 5. The elimination of maternal mortality and morbidity is addressed through multidisciplinary responses, including assuring quality functional literacy classes; identifying the diverse social and cultural structures that influence the lives of women and girls; and studying women's health and status and their association with pregnancy, childbirth and neonatal care. Attention has also been given to increasing the awareness of, and capacity for protecting, the rights of women and girls, including reproductive rights and maternal health.

50. According to UNICEF (in a contribution to the present report), women who have been to school are less likely to die during childbirth and more likely to take good care of their children. UNICEF has therefore been supporting projects to empower girls and women through, inter alia, ensuring that girls stay in school.

51. Improving maternal health and empowering women include ensuring involvement of partners, communities and Governments in achieving this objective. In India, UNICEF supported the Government in determining the underlying causes

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[22] See the report on the implementation of the Agenda (UNAIDS/PCB(28)/11.5) submitted to the Programme Coordinating Board of UNAIDS at its twenty-eighth session, held from 21 to 23 June 2011.

[23] Cambodia, Côte d'Ivoire, Haiti, India, Jamaica, Kenya, Liberia, Pakistan, Papua New Guinea, Rwanda, Serbia, South Africa, the Sudan and Ukraine.

[24] *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015* (Geneva, 2011).

of maternal mortality. The Maternal and Perinatal Death Inquiry and Response (MAPEDIR) initiative used a tool for identifying the personal, familial, sociocultural, economic and environmental factors that contribute to such deaths.

52. Various entities have contributed to initiatives for reducing maternal mortality and morbidity through education, advocacy, training and research. Formal publications (WHO) and capacity-building and awareness-raising at the country level (International Labour Organization (ILO) and UNESCO), as well as liaison with the media and media outreach (Department of Public Information of the United Nations Secretariat) have been utilized.

53. WHO has supported policy-relevant research, providing important tools and evidence which contribute significantly to expanding access to essential sexual and reproductive health interventions, including family planning, and maternal health services, as well as promoting women's empowerment. UNAIDS supported a study of access to reproductive and maternal health services by women living with HIV in six countries in Asia. UNFPA supports advocacy on Millennium Development Goal 5 at the global level.

54. UNHCR has strengthened its maternal health programme, including emergency obstetric and neonatal care at all levels, encompassing the community, labour rooms and referral facilities. Services have been provided for internally displaced persons, urban refugees and returnees. UNHCR continues to promote and support the implementation of a minimum initial service package at the immediate onset of new emergencies, which scales up to a comprehensive and integrated sexual and reproductive health programme that increases access to quality emergency obstetric care, while expanding family planning opportunities and services for sexually transmitted infections including HIV/AIDS.

C. Major global initiatives

55. Of recent global initiatives, the most promising with respect to addressing a range of issues at the root of persistent maternal mortality is the Every Woman Every Child initiative, which was launched by the United Nations Secretary-General under the Global Strategy for Women's and Children's Health, with the aim of saving the lives of 16 million women and children by 2015. The Global Strategy, with a budget of $40 billion, constitutes an unprecedented global effort which mobilizes and intensifies international and national action by Governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children. The Global Strategy has devised a road map on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children. In May 2011, 16 countries announced their commitments to the initiative, largely in the form of budgetary increases for maternity and prenatal care.

56. Every Woman Every Child is aware of the link between Millennium Development Goals 5 and 4, and all the other Goals, and recognizes that the empowerment of women and gender equality improve the health of women and children through the resultant increase in the range of reproductive choices, reduction of child marriages and tackling of discrimination and gender-based violence. In connection with the launch of this initiative, a Commission on

Information and Accountability was established to ensure effective and efficient delivery and use of the resources raised.

57. The Group of Eight (G8) Muskoka Initiative supports strengthened country-led national health systems in developing countries designed to enable delivery of key interventions along the continuum of care. It emphasizes strengthening health systems, expanding sexual and reproductive health services, including family planning, addressing gender inequality and promoting the human rights of girls and women. Through this initiative, G-8 Governments will provide 5 billion United States dollars between 2010 and 2015. An additional $2.3 billion will come from other Governments — the Netherlands, New Zealand, Norway, the Republic of Korea, Spain and Switzerland — and the United Nations Foundation and the Bill and Melinda Gates Foundation.

58. To accelerate efforts to save the lives of women and newborns, WHO, UNFPA, UNICEF and the World Bank, in 2008, issued a Joint Statement on Maternal and Newborn Health and committed to redoubling their joint efforts in this regard. They were later joined by UNAIDS. Commonly known as the H4+, these organizations have embarked on a major programme of work on behalf of the 50 countries with the highest newborn and maternal health burden.

59. The Global Health Initiative launched by the President of the United States of America, Barack Obama, will be implemented in all countries receiving United States health assistance. Eight countries — Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal and Rwanda — will receive additional technical, management and financial resources to enable them to quickly implement the approach set out by the Initiative, including integrated programmes and investments over the entire spectrum of infectious diseases, and maternal and child health, family planning, and health systems activities.

60. The Mandang Commitment emerged from the 2009 biennial Meeting of Ministers of Health for the Pacific Island Countries. The Addis Call to Urgent Action for Maternal Health, launched in 2009, called for the enactment and enforcement of laws and policies on a minimum age at marriage of 18 years, on respecting girls' human rights and on preventing risks associated with child marriage and adolescent pregnancies, and ensuring that health systems were gender-sensitive and culturally sensitive and community-oriented, and created demand for provision of effective services and infrastructure. The Addis Ababa Statement of Commitment, which emerged from the Fourth International Parliamentarians' Conference on the Implementation of the International Conference on Population and Development Programme of Action (27 and 28 October 2009), firmly recognized the promotion of gender equality and the empowerment of women as one of nine areas of focus towards achieving Millennium Development Goal 5.[25]

61. The International Initiative on Maternal Mortality and Human Rights was launched in 2007 as the first civil society human rights effort aimed at reducing maternal mortality. The Initiative was launched by a partnership of international, regional and national civil society organizations committed to a comprehensive

[25] Others include awareness-raising and advocacy; budget and oversight responsibilities; legislative and policy responsibilities; empowerment of young people; strengthening health systems; promoting access to sexual and reproductive health, including family planning; ensuring adequate financing; and addressing climate change and emerging population issues.

human rights approach to maternal mortality, including a call for greater political will on the part of Governments and donors in respect of taking the necessary steps to reduce maternal mortality, and in turn, more and better accountability mechanisms for ensuring that women's right to maternal health becomes a reality.[26] With projects in India, Kenya and Peru, the International Initiative seeks to increase understanding of how to integrate human rights ideas and approaches into maternal mortality work at national, subnational and local levels. It also seeks to build bridges among human rights, public-health and women's rights groups.

V. Initiatives to strengthen data and knowledge on maternal mortality

62. In developing countries where accurate medical records may not exist, where the pregnancy status of a woman before her death may be unknown or concealed owing to social, cultural or religious factors, and where cause-of-death data may be missing or unreliable, many maternal deaths are likely to be missed. In the absence of reliable civil registration systems, indirect methods of estimation have been used. Yet, reliable data that are disaggregated by sex and age are essential for addressing maternal mortality from a human rights and gender-equality perspective.

63. There has been progress in ensuring linkages in this area across initiatives which have slowly moved away from an approach based on the endeavours of individual United Nations entities or academics towards one that is more integrated and harmonious.

64. The Maternal Mortality Estimation Inter-Agency Group, composed of WHO, UNICEF, UNFPA and the World Bank, and an independent Technical Advisory Group, now works to review and generate estimates of maternal mortality. It has developed maternal mortality estimates using statistical modelling for countries where no reliable data exist and has updated existing estimates.

65. The United Nations Statistics Division has continued to maintain and improve the Millennium Development Goals Indicators database and website,[27] working in this regard through the Inter-Agency and Expert Group on Millennium Development Goals Indicators and its thematic subgroups. In particular, international organizations responsible for the production of estimates and the compilation of indicators for monitoring Goal 5 and the two targets related thereto have strengthened their collaboration and carried out a number of initiatives at the regional and international levels, including training workshops on estimation methods and indicators metadata, for experts from national statistical offices and health ministries; consultations with national counterparts on the production of estimates; and data analysis and dissemination efforts.

66. Member States also continue to work to improve national data collection and analysis in the area of maternal mortality and morbidity. In New Zealand, the Perinatal and Maternal Mortality Review Committee collects data on all perinatal and maternal deaths in the country and produces a report that identifies contributing factors and deaths that were possibly avoidable. Data are also collected on maternal

[26] See http://righttomaternalhealth.org/.

[27] http://mdgs.un.org.

morbidity. A maternity standards guide has been established in the context of the provision and monitoring of maternity services. These data are provided regularly to WHO, the Organization for Economic Cooperation and Development (OECD) and Eurostat, thus allowing close monitoring of progress.

VI. The catalytic role of UN-Women

67. With its mandate to lead and coordinate the gender-equality work across the United Nations system, UN-Women works to support the forging of strong links across entities with a view to promoting gender equality and the empowerment of women in all areas of work.

68. Without seeking to replace or duplicate the work of other entities that have clear comparative advantage in the area of maternal mortality, UN-Women will help to advance women's leadership and participation, ensuring that countries have access to the best knowledge and technical expertise so as to enable a strong gender-equality and women's empowerment perspective to emerge. Through its emphasis on women's economic empowerment, UN-Women will strengthen capacity at the country level so as to ensure a gender equality-responsive implementation of programmes and projects on maternal mortality.

69. A core aspect of the work of UN-Women comprises its efforts to address and reverse gender inequality and gender stereotyping which are at the basis of prevailing and persistent high maternal mortality. In this respect, the emphasis of UN-Women is complementary to the focus of other entities that are addressing the direct causes of maternal mortality and morbidity. The support provided by UN-Women to Member States with respect to developing gender-responsive budgets will also ensure that adequate resources are allocated to gender equality in development activities. UN-Women promotes the participation of women in decision-making in all contexts, including post-conflict ones, where the reproductive health and rights of women are subject to particular risks and where sexual violence and rape contribute to exceptional levels of maternal morbidity and mortality. Through its emphasis on women's economic empowerment, UN-Women will strengthen women's capacity to make decisions concerning their reproductive health, including with respect to accessing reproductive health services and commodities.

70. UN-Women's goal of increasing the level of women's leadership and participation is central to the elimination of maternal mortality. The participation and leadership of women are essential to achieving the full human rights and gender-equality perspective required to address maternal mortality. They ensure that interventions are familiar, fully owned and remain relevant. Effective policies and programmes for addressing maternal mortality and morbidity cannot be designed without the participation of women.

71. Two important roles for UN-Women, as outlined in its strategic plan 2011-2013 and its Development Results Framework, lie in ensuring that the global policy and normative framework for gender equality and women's empowerment are reaffirmed, strengthened and deepened and in increasing the extent to which sectoral global policy and normative frameworks reflect gender-equality and women's empowerment perspectives. To this end, UN-Women will work with other entities to ensure that a gender-equality perspective emerges and is strengthened in sectoral

work conducted to support the elimination of maternal mortality. UN-Women will also promote a link between relevant normative agreements on maternal mortality and operational experiences, including through the Commission on the Status of Women, and in the work of the broader intergovernmental machinery.

VII. Conclusions and recommendations

72. In recent years, the importance of a human rights and gender-equality approach to achieving Millennium Development Goal 5 has been clearly acknowledged and codified in intergovernmental norms. From this perspective, it is recognized both that a medical approach and availability of services, while essential, are insufficient and that a gender-equality approach is needed to address the root causes of maternal mortality and to ensure that quality services are accessible to and affordable by all.

73. According to the Office of the United Nations High Commissioner for Human Rights, the most effective examples of the human rights approach to addressing maternal mortality involve a combination of sustained efforts to address the underlying causes of maternal mortality and a strengthening of government commitments to ensuring better access to high-quality health care and fostering the empowerment of women.

74. The present report suggests that a consistent and sustained human rights approach that emphasizes a comprehensive set of interventions that are responsive to human rights and gender equality and the empowerment of women has not quite emerged. Existing initiatives and programmes have undoubtedly contributed to recently recorded reductions in maternal mortality; however, there is no evidence of the application of this sustained approach.

75. In initiatives and programmes undertaken by Member States, and to a lesser extent by the United Nations system, maternal mortality and morbidity are being addressed primarily as medical issues. Comprehensive initiatives to address well-known challenges such as malaria are lacking. Laws have been adopted in some countries to halt female genital mutilation, but there is little evidence of a comprehensive global approach to this violation of the rights of girls and women as well as to addressing all forms of violence against women and girls in the context of pregnancy and childbearing.

76. The slow emergence of a sustained human rights and gender-equality approach that addresses all the elements identified by the Human Rights Council as being essential to this approach can be attributed to many factors.

77. Member States and United Nations entities have themselves reported various constraints on their efforts to eliminate maternal mortality, including high levels of illiteracy, cultural and religious obstacles, poor health infrastructure, inadequate training for health personnel, and challenges associated with high population growth.

78. Geographical isolation resulting in high costs of serving dispersed populations, including rural women, has constrained progress of some Member States. Shortage of staff at the referral levels, insufficient funding for maternal and child health programmes, and lack of maternity waiting homes in some regions, in addition to

lack of skilled personnel and their unequal distribution between urban and rural areas, have been reported.

79. Although a number of countries have achieved low levels of maternal mortality, significant pockets of vulnerable and disadvantaged groups still remain. There are special challenges with respect to the provision of adequate maternity care and reproductive health services for particularly vulnerable groups, namely, rural women; women with HIV/AIDS; adolescents; women with disabilities; and indigenous women. The human rights of these groups are often disregarded, particularly in the context of pregnancy and childbirth.

80. The Permanent Forum on Indigenous Issues has thus repeatedly recommended that measures devised to address the maternal health of indigenous women should first of all foresee the need for culturally appropriate health services. Services must be developed with respect for and in accordance with their traditions of health and well-being, and provided in the native languages and in a culturally appropriate setting. Women should be able to participate in shaping their own health care, including antenatal care and delivery.

81. Similarly, evidence concerning reproductive health services available to women with disabilities suggests that those women are often excluded from family planning and education (including sexual education) services. Indeed, service providers may believe incorrectly that women with disabilities are not in need of reproductive health services, because they are either not sexually active or not capable of becoming pregnant. Health-care providers need to acquire education and experience in working with patients with disabilities so as to ensure that the rights of women with disabilities are respected during pregnancy and post-partum.

82. **In view of the clear evidence of a fragmented approach to addressing the elimination of maternal mortality and morbidity, a concerted effort is required to accelerate the emergence of a clear-cut and sustained human rights approach. This approach must be comprehensive and holistic and include a broad range of programmes as well as services.**

83. **Broad social changes are needed to address the vulnerability of women and girls to discrimination, abuse and gender-based violence, including female genital mutilation. Access to education and information on reproductive health care and services as well as interventions to address the threat, inter alia, of malaria, anaemia and HIV/AIDS are needed.**

84. **Quality care before, during and after pregnancy must be provided, and women's and girls' needs for adequate nutrition, clean water and sanitation, as well as the need for access by pregnant women to prenatal and post-natal care, must be met. Provision must also be made for access to comprehensive primary health services, and adequate infrastructure, including the transportation and communication systems required to handle emergency obstetric events.**

85. **Given the strong interrelationships among root causes, efforts to address maternal mortality must also focus on meeting Millennium Development Goals 3, 5 and 6 jointly in order to combine the benefits of promoting gender equality and empowerment of women; improving maternal health; and combating HIV/AIDS, malaria and other diseases. While working towards the elimination of new HIV infections among women and girls, it is important to ensure that pregnant women with HIV/AIDS are protected from the discrimination in**

service and care that could jeopardize their lives as well as the lives of their offspring. Access to antiretroviral treatment for those who are infected must be ensured.

86. **Efforts to eliminate all forms of discrimination against women and girls, and to end all forms of violence, including female genital mutilation, against women and girls must be strengthened. These efforts must be backed by appropriate legislation and enforcement.**

87. **Affordable, accessible care, particularly emergency obstetrics care, is essential to a rights-based approach to eliminating maternal mortality. Effective treatment and follow-up must be provided in event of an emergency obstetric event or maternal morbidity.**

88. **Finally, the promotion of gender equality and the empowerment of women and adolescent girls within their communities, so as to enable them to participate in all aspects of decision-making on their reproductive lives, maternity, post-natal well-being and sexual and reproductive health, must become key elements of all human rights-based initiatives to address maternal mortality and morbidity.**

89. **Implementing these interventions will require renewed dedication and a commitment of resources, as well as a solid system of accountability. The Commission on Information and Accountability of the Every Woman Every Child Initiative constitutes a good model in this regard.**

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