United Nations E/CN.6/2014/11

Economic and Social Council

Distr.: General
19 December 2013

Original: English

Commission on the Status of Women
Fifty-eighth session
10-21 March 2014
Item 3 (c) of the provisional agenda*
Follow-up to the Fourth World Conference on Women and to the twenty-third special session of the General Assembly, entitled "Women 2000: gender equality, development and peace for the twenty-first century"

Actions to strengthen linkages between gender equality and the empowerment of women and girls, and the elimination of preventable maternal mortality and morbidity

Report of the Secretary-General

Summary

Pursuant to resolution 56/3 of the Commission on the Status of Women, the present report reviews the actions taken to strengthen linkages among programmes, initiatives and activities throughout the United Nations system in respect of gender equality, the empowerment of women and girls, the protection of all their human rights and the elimination of preventable maternal mortality and morbidity. The report includes submissions and contributions from 15 Member States and 12 United Nations entities, and concludes with recommendations for consideration by the Commission.

* E/CN.6/2014/1.

13-62789 (E) 090114

I. Introduction

1. In its resolution 56/3 on eliminating maternal mortality and morbidity through the empowerment of women, the Commission on the Status of Women expresses deep concern about the more than 350,000 women and adolescent girls who still die every year from largely preventable complications related to pregnancy or childbirth; expresses concern about the slow pace of progress in improving maternal, newborn and child health and the inadequate resources for their health; notes the continuing inequalities among and within Member States and the continuing need to address gender inequalities; and urges Member States to accelerate progress towards the attainment of Goal 5 of the Millennium Development Goals. The 2015 targets of the Goal are to reduce by 75 per cent the maternal mortality ratio and to achieve universal access to reproductive health. Accordingly, the Secretary-General was requested to submit a report to the Commission at its fifty-eighth session, taking into account relevant United Nations resolutions, on actions taken 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.

2. In the present report, the Secretary-General takes into account Human Rights Council resolution 18/2 on preventable maternal mortality and morbidity and human rights, in which the Council encouraged States and other relevant stakeholders 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. The report underscores the relevance of maternal mortality as a health, development and human rights issue, summarizing current initiatives and information on the progress of actions taken at all levels by Member States,[1] United Nations entities[2] and civil society organizations during the period from September 2012 to November 2013.

II. Global status of maternal mortality and morbidity

3. A maternal death is defined 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.[3] Maternal morbidity is a

[1] Member States include Argentina, Burkina Faso, Cameroon, Colombia, Ecuador, Germany, Latvia, Norway, Peru, the Philippines, Poland, Qatar, the Netherlands, Togo and Turkey.

[2] United Nations entities include the Economic and Social Commission for Asia and the Pacific (ESCAP), the International Telecommunication Union (ITU), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Industrial Development Organization (UNIDO), the United Nations Research Institute for Social Development (UNRISD), the World Food Programme (WFP), the World Health Organization (WHO) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women).

[3] World Health Organization. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/.

complication or illness that arises during gestation, birth or the period after childbirth, which affects the woman's integrity, and physical or mental health.[4]

4. According to the *Millennium Development Goals Report 2013*, the maternal mortality ratio has declined globally by 47 per cent, from 400 maternal deaths per 100,000 live births in 1990 to 210 maternal deaths per 100,000 live births in 2010 (see table below). However, there remain large disparities in maternal mortality ratios across and within countries. The vast majority of maternal deaths occur in developing countries. In *Trends in Maternal Mortality: 1990 to 2010 — WHO, UNICEF, UNFPA and the World Bank Estimates*, the World Health Organization (WHO) reports that over half of annual maternal deaths (240,000) occur in sub-Saharan Africa (56 per cent) and a third in South Asia (29 per cent), together accounting for 85 per cent of the global burden, followed by Oceania, South-Eastern Asia, Latin America and the Caribbean, North Africa, Western Asia and the Caucasus and Central Asia. The maternal mortality ratio is 15 times higher in developing countries than in high-income countries. Of the 75 countries with the highest maternal mortality ratios, 2 countries account for a third of global maternal deaths: India, at 19 per cent (56,000), and Nigeria, at 14 per cent (40,000).

5. In the same publication, WHO reports that, on a global level, 30 countries achieved reductions of 50 per cent or more in the maternal mortality ratio between 1990 and 2010, and 3 countries (Equatorial Guinea, Nepal and Viet Nam) achieved reductions of at least 75 per cent. Over 50 countries reduced maternal mortality during the period 2000-2010 at a faster rate than during the previous decade, indicating that the pace of progress is improving. Nine sub-Saharan African countries with high HIV prevalence, protracted armed conflict and economic instability have experienced increases in their maternal mortality ratio in the past 20 years.[5]

Estimates of maternal mortality ratios, number of maternal deaths and lifetime risk of maternal death by Millennium Development Goals region/area, 2010

Region/area	*Maternal mortality ratio*[a]	*Number of maternal deaths*[a]	*Lifetime risk of maternal death (ratio)*[a]
Global	210	287 000	1/180
Developed regions[b]	16	2 200	1/3 800
Developing regions	240	284 000	1/150
Northern Africa[c]	78	2 800	1/470
Sub-Saharan Africa[d]	500	162 000	1/39
Eastern Asia[e]	37	6 400	1/1 700
Southern Asia[f]	220	83 000	1/160
South-Eastern Asia[g]	150	17 000	1/290
Western Asia[h]	71	3 500	1/430
Caucasus and Central Asia[i]	46	750	1/850

[4] Maternal Mortality Estimation Inter-Agency Group, *Trends in Maternal Mortality: 1990 to 2008 — Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, p. 19 (Geneva, World Health Organization, 2010), available from http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf.

[5] WHO and UNICEF, *Countdown to 2015: Maternal, Newborn and Child Survival — Accountability for Maternal, Newborn and Child Survival: the 2013 Update* (Geneva, 2013).

Region/area	*Maternal mortality ratio*[a]	*Number of maternal deaths*[a]	*Lifetime risk of maternal death (ratio)*[a]
Latin America[j]	72	7 400	1/580
Caribbean[k]	190	1 400	1/220
Oceania[l]	200	510	1/130

Source: Maternal Mortality Estimation Inter-Agency Group, *Trends in Maternal Mortality: 1990 to 2010 — Estimates Developed by WHO, UNICEF, UNFPA and the World Bank* (WHO, Geneva, 2012).

Note: Estimates derived from household surveys are subject to wide confidence intervals and long period rates (often, 10-year periods). Global and regional estimates of maternal mortality are developed every five years, using a regression model.

[a] The maternal mortality ratio, number of maternal deaths and lifetime risk of maternal death have been rounded according to the following scheme: less than 100, no rounding; 100-999, rounded to nearest 10; 1,000-9,999, rounded to nearest 100; and more than 10,000, rounded to nearest 1,000.

[b] Albania, Australia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, the former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland, United States of America.

[c] Algeria, Egypt, Libya, Morocco, Tunisia.

[d] Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

[e] China, Democratic People's Republic of Korea, Mongolia, Republic of Korea.

[f] Afghanistan, Bangladesh, Bhutan, India, Iran (Islamic Republic of), Maldives, Nepal, Pakistan, Sri Lanka.

[g] Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste, Viet Nam.

[h] Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, United Arab Emirates, Yemen, West Bank and Gaza Strip.

[i] Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan.

[j] Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, Venezuela (Bolivarian Republic of).

[k] Bahamas, Barbados, Cuba, Dominican Republic, Grenada, Haiti, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Puerto Rico.

[l] Fiji, Micronesia (Federated States of), Papua New Guinea, Solomon Islands, Tonga, Vanuatu.

6. Globally, the major causes of maternal deaths are haemorrhage, infection/sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labour.[6] According to the *Millennium Development Goals Report 2013*, many pregnant women in developing countries still do not receive the minimum standard of antenatal care and are not attended to by skilled medical personnel at the time of delivery. In 2011, women delivered alone or with inadequate care in approximately

[6] Contribution of UNFPA.

46 million of the 135 million live births in developing countries. The situation of pregnant women is even more challenging in remote and rural areas, where only 53 per cent of rural and indigenous women receive skilled assistance at delivery, as compared with 84 per cent in urban areas.

7. Estimates suggest that 13 per cent of all maternal deaths are a result of unsafe abortions.[7] The risk of maternal death due to unsafe abortion remains high in Africa and Asia.[8] The Programme of Action of the International Conference on Population and Development recognizes unsafe abortions as a major public health concern, given the grave risks women may face in the aftermath of an unsafe abortion procedure. In order to ensure women's right to health and life, where access to abortions is legally restricted, the provision of post-abortion care is critical to prevent poor health outcomes (see A/HRC/18/27).

8. In a number of countries, high fertility rates continue to account for high maternal mortality. Of 75 countries with high maternal mortality and morbidity, more than half have a total fertility rate of 4.0 children per woman or higher; 35 of those countries are in sub-Saharan Africa, with 21 in West and Central Africa and 14 in Eastern and Southern Africa. Such a concentration of high fertility is matched by generally low levels of contraceptive use.[9]

9. Access to family planning services reduces unintended and high-risk pregnancies and unsafe abortions, and thus reduces maternal mortality. The *Millennium Development Report 2013* indicates that the proportion of couples using contraception has increased in a number of countries, including in developing countries. However, the global unmet need for family planning — defined as the percentage of women aged 15-49, married or in union, who report the desire to delay or avoid pregnancy but are not using any form of contraception — has declined only slightly, from 15 per cent in 1990 to 12 per cent in 2011, which translates into more than 140 million women.

10. HIV/AIDS and malaria remain significant contributing causes of maternal deaths, and they work individually or together to account for about 20 per cent of maternal deaths. In 15 countries with HIV prevalence above 5 per cent, indirect maternal deaths attributable to AIDS range from 8 per cent to 67 per cent.[10] Cumulatively, as at December 2012, over 900,000 pregnant women living with HIV globally received antiretroviral prophylaxis or treatment.[11] Coverage varies substantially across and within countries. Accounting for approximately 10,000 maternal deaths globally every year, malaria is a serious illness that predisposes pregnant women to severe anaemia and death and is associated with low birth weight and stillbirths.[12] In areas endemic for malaria, it is estimated that at least 25 per cent of pregnant women are infected. An estimated 32 million pregnant

---

[7] Lisa B. Haddad and Nawal M. Nour, "Unsafe abortion: unnecessary maternal mortality", *Reviews in Obstetrics and Gynecology*, vol. 2, No. 2 (Spring 2009), pp. 122-126.

[8] WHO, *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2008* (Geneva, 2011).

[9] *Countdown to 2015: 2013 Update* (see footnote 5 above), p. 22.

[10] WHO and UNICEF, *Countdown to 2015: Maternal, Newborn and Child Survival — Building a Future for Women and Children: The 2012 Report* (Geneva, 2012).

[11] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, 2013), p. 38.

[12] Julianna Schantz-Dunn and Nawal M. Nour, "Malaria and pregnancy: a global health perspective", *Reviews in Obstetrics and Gynecology*, vol. 2, No. 3 (Summer 2009), p. 188.

women could benefit from preventative treatment for malaria each year. According to the *World Malaria Report 2013*, 64 per cent of pregnant women in 2012 received one dose of intermittent preventive treatment during pregnancy, whereas only 23 per cent received the three doses recommended by WHO, indicating room for improvement in providing protection for pregnant women from malaria.

III. Maternal mortality and morbidity as a human rights issue

11. International treaties such as the International Covenant on Economic, Social and Cultural Rights, the Beijing Platform for Action, the Programme of Action of the International Conference on Population and Development and the Convention on the Elimination of All Forms of Discrimination against Women prescribe specific rights related to women's health, including prevention of maternal mortality and morbidity. In its resolution 11/8, the Human Rights Council identifies a range of human rights directly implicated by maternal mortality and morbidity, namely, the 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, the right to be free from cruel, inhumane and degrading treatment, the right to privacy and the right to an effective remedy. Such rights can only be guaranteed where there is adherence to principles of gender equality, participation, transparency and accountability.

12. It has been increasingly recognized that the failure to address preventable maternal disability and death represents one of today's greatest social injustices and that the reproductive health risks of women are injustices that societies are able and obligated to remedy. Increasingly reducing maternal mortality and morbidity is not solely seen as an issue of development, but a matter of human rights. The Office of the United Nations High Commissioner for Human Rights (OHCHR), in collaboration with WHO, the United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF), prepared technical guidance on the application of a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity. The guidance highlights specific groups of women who suffer multiple forms of discrimination, and as a consequence higher rates of maternal mortality and morbidity, and stresses the right of women to participate in decision-making affecting their sexual and reproductive health and rights. It further emphasizes the need for State accountability and that States are obliged to ensure that third parties do not interfere with the enjoyment of sexual and reproductive rights (see A/HRC/21/22).

IV. Root causes of maternal mortality and morbidity

13. In its resolution 56/3, the Commission on the Status of Women recognizes that the root causes of preventable maternal mortality and morbidity encompass a wide range of interlinked underlying factors related to development, human rights and health, including poverty, illiteracy, discrimination against women and girls, gender-based violence, lack of participation in decision-making, poor health infrastructure and inadequate training for health personnel.

14. Education, along with the presence of a skilled attendant at birth, access to resources and health expenditures, show consistent correlations with lower maternal mortality ratios.[13] In countries where women hold a higher proportion of seats in parliament and where a higher proportion of girls complete primary education there are lower levels of maternal mortality.[13] This suggests that enabling environments for gender equality are inextricably linked to positive reproductive health outcomes.[13] In addition, evidence shows that the impact of coverage of health interventions such as skilled attendance at birth is greater among women with secondary or higher education than for women with no education.[13] This indicates that education is a powerful tool in the empowerment of women and girls, enabling them to make informed choices regarding their reproductive health and to seek proper health care.

15. Gender norms and inequalities play a large role in shaping the vulnerabilities and negative outcomes associated with maternal health. In many settings, women's lack of agency, while exacerbated by limited education, can be traced to social norms and how the formal and customary legal system is designed and administered. Laws requiring parental notification and/or allowing husbands or partners to veto use of contraception and reproductive health services limit girls and women from accessing contraception, family planning, safe abortion, where legal, and other essential reproductive health services.[14]

16. Practices such as child, early and forced marriages are powerful drivers of maternal mortality and morbidity. Child marriage is statistically associated with lower use of contraceptives, higher fertility, multiple unwanted pregnancies, delivery without skilled attendance, and short birth spacing, all important risk factors for maternal mortality and morbidity.[15] In addition, child marriage affects educational advancement opportunities and limits future economic earnings potential. Every year, 14 million girls under age 18 get married, and the global proportion of all girls married under age 18 is 36 per cent.[16] Marriage rates among girls under 18 years are as high as 45 per cent in South Asia.[15] Besides early marriage, young women and adolescent girls who are sexually active, have limited knowledge of and access to reproductive health information and services and are at increased risk of (unwanted) pregnancy, unsafe abortion and childbirth-related complications, particularly obstetric fistulas, which are among the leading causes of death among girls aged 15 to 19.[17]

---

[13] Karen A. Grépin and Jeni Klugman, "Investing in women's reproductive health: closing the deadly gap between what we know and what we do", World Bank Background Paper, Women Deliver 2013.

[14] R. C. Pacagnella and others, "The role of delays in severe maternal morbidity and mortality: expanding the conceptual framework", *Reproductive Health Matters*, vol. 20, No. 39 (June 2012), pp. 155-163.

[15] Minh Cong Nguyen and Quentin Wodon, "Global trends in child marriage", World Bank Working Paper, 2012.

[16] Independent Expert Review Group, *Every Woman, Every Child: Strengthening Equity and Dignity through Health: The Second Report of the Independent Expert Review Group on Information and Accountability for Women's and Children's Health* (Geneva, WHO, 2013), p. 60.

[17] UNFPA, *State of World Population 2013: Motherhood in Childhood — Facing the Challenge of Adolescent Pregnancy* (New York, 2013).

17. Financial and physical barriers, social restrictions that limit mobility, inadequate transportation options, low quality health services and the lack of knowledge about where to deliver are frequently cited as reasons for not seeking care.[18] In the absence of social protection mechanisms, the high cost of health care constrains women's access to antenatal, intra-partum and post-partum care, and could have a detrimental effect on the economic well-being of families.[19] Systematic reviews of national programmes that reduce financial barriers, such as the provision of vouchers, free services and cash transfers, have shown to effectively improve health outcomes, including maternal health. Women exposed to such programmes, especially younger mothers, were shown to be more likely to both access antenatal care and select health-care providers for delivery who were more skilled.[20]

18. Access to reproductive health services is further complicated during natural disasters and armed conflict owing to the destruction of health-care facilities and overall insecurity, impeding pregnant women from seeking medical care.[21] Trauma, exposure to violence and poor sanitation conditions may also contribute to worsening maternal mortality and morbidity outcomes during crises. Women may also be more at risk of sexual violence, which can result in unwanted pregnancies and, in turn, to unsafe abortions.

V. Actions taken by Member States and United Nations entities

19. Over the past year, Member States and United Nations entities have taken actions to empower women and girls, promote their rights and reduce maternal mortality and morbidity through the development of human rights frameworks, national plans, strategies and financing, reproductive health services, resource mobilization, accountability and data mechanisms and attention to emergency obstetric and newborn needs assessments, as well as maternal mortality surveillance.

A. Development of human rights frameworks

20. Member States affirmed their commitments to human rights-based approaches through a call to action on family planning during the Women Deliver 2013 Conference and regional consultations held in 2012 (Benin, Ethiopia, Nigeria, Senegal, South Sudan and Uganda). In presentations at key international, regional and national events, OHCHR has actively engaged in the promotion of technical guidance to apply a human rights-based approach in policies and programmes to reduce preventable maternal mortality and morbidity. A joint initiative between OHCHR, WHO, UNFPA and the Partnership for Maternal, Newborn and Child Health is currently under way in select countries and aims to apply rights-based approaches to

[18] See, for example, S. Gabrysch, V. Simushi and O. M. R. Campbell, "Availability and distribution of, and geographic access to emergency obstetric care in Zambia", *International Journal of Gynecology and Obstetrics*, vol. 114, No. 2 (August 2011), pp. 174-179.

[19] V. Filippi and others, "Maternal health in poor countries: the broader context and a call for action", *Lancet*, vol. 368, No. 9546 (October 2006), pp. 1535-1541.

[20] S. Dzakpasu, T. Powell-Jackson and O. M. R. Campbell, "Impact of user fees on maternal health service utilization and related health outcomes: a systematic review", *Health Policy Plan* (January 2013).

[21] James Price and Alok Bohara, "Maternal health care amid political unrest: the effect of armed conflict on antenatal care utilization in Nepal", *Health Policy Plan* (2012).

sexual, reproductive, maternal and child health. OHCHR and UNFPA also collaborated with national human rights institutions at the eleventh international conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, held in Amman in November 2012, to raise awareness about sexual and reproductive health and rights, and maternal mortality and morbidity as human rights issues and adopted the Amman Declaration.

B. National plans, strategies and financing

21. Member States reported on key national planning strategies that cover the development of legal and policy frameworks, social protection programmes, provision of sexual and reproductive health services, family planning, awareness-raising and comprehensive sexuality education. In addition, focused initiatives targeting specific maternal health issues and particular groups of women and parts of the population were carried out (Argentina, Burkina Faso, Cameroon, Ecuador, Latvia, Peru, Philippines, Poland, Qatar, Togo and Turkey). Innovations introduced in national plans included on-site maternal waiting homes, where pregnant women await delivery to ensure access to skilled attendance (Burkina Faso and Peru).

22. Men can play an important role in eliminating preventable maternal mortality and morbidity. For example, religious and community leaders can be key partners in promoting gender equality and addressing violence against women, and harmful practices and cultural norms that affect maternal health. Member States and United Nations entities have been scaling up efforts to engage men through "husbands school" interventions, which provide information, education and opportunities for community involvement for husbands to learn about maternal and child health (Burkina Faso, Guinea and Niger).[22]

23. National health-care financing and tracking interventions that monitor resource allocation to reproductive health services have been instituted in Member States (Afghanistan, Liberia, Rwanda, United Republic of Tanzania and Ukraine), supported by the United States Agency for International Development (USAID). National health accounts enable Governments to monitor the performance of the health sector, providing stakeholders with information on the overall resource allocation.

24. Regional and global guidance for the development of national action plans is critical. To that end, the action plan for maternal and child health by the African Union Commission provides guidance through advocacy, technical leadership, and accountability and governance mechanisms, and by addressing key areas such as health-care financing.

25. A part of the "Every Woman, Every Child" movement, and the Health Four Plus Partnership, comprising WHO, UNFPA, UNICEF, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the World Bank, also support the efforts of States in developing and implementing national plans, including through various global initiatives aimed at improving maternal health, expanding family planning services and ending mother-to-child transmission of HIV.

[22] WHO, *The H4+ Partnership: Joint Country Support to Improve Women's and Children's Health* (Geneva, 2013), p. 14.

C. Reproductive health services

26. Member States have expanded accessibility to quality maternal, neonatal and child health services through sector-wide approaches and targeted interventions.

27. In the area of human resources for health and health worker training, States (Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cameroon, Djibouti, Democratic Republic of the Congo, Ethiopia, Ghana, India, Côte d'Ivoire, Madagascar, Mali, Mozambique, Nigeria, Sudan, South Sudan, United Republic of Tanzania and Togo), United Nations entities (UNFPA, WHO), and other partners, through the Maternal Health Thematic Fund collaborated with the International Confederation of Midwives, trained over 1,500 midwifery tutors, built new training sites, strengthened over 175 midwifery schools, upgraded provider skills to manage fistula and created multimedia e-learning solutions.[22]

28. Member States have scaled up efforts to expand the availability of family planning services, including through legislation enabling women to access services without the consent of their spouse, and cost subsidization measures (Benin, Burkina Faso, Guinea, Niger, Ethiopia, Nigeria, Senegal, South Sudan and Uganda). At the London Summit on Family Planning held in 2012, in support of the Every Woman Every Child initiative, 24 Governments committed to increasing resources to expand family planning services to reach 120 million women in developing countries by 2020.

29. United Nations entities have actively partnered with States to strengthen health services, as demonstrated in the Health Four Plus programmes. In order to improve the quality of health-care interventions, UNICEF, in partnership with UNFPA and Columbia University (New York), carried out needs assessments in 30 countries. Key strategies identified included generating demand and community support for health services and awareness-raising, sound referral systems, outreach to vulnerable and hard-to-reach populations, improvements to transportation infrastructures and financial support.[23] Other interventions related to the quality of the care included upgraded advisories on the treatment of malaria during pregnancy (WHO) and the development of toolkits by Pathfinder International to aid health-care workers in the treatment of postpartum haemorrhage.

30. The Global Programme to Enhance Reproductive Health Commodity Security has mobilized approximately $565 million since 2007 to ensure access to reproductive health commodities and develop sustainable approaches to procurement, benefiting over 35 countries.

31. To improve pregnant women's health outcomes, the World Food Programme's nutrition programmes supported 3.9 million pregnant and lactating women globally and 250,000 women in Niger and Kenya to prevent acute malnutrition.[24]

32. To address maternal health services during humanitarian crises, UNFPA regularly ships family planning, prenatal and clean delivery kits to prevent fatal infections supplies within hours of emergencies.[25]

---

[23] Contribution of UNICEF.

[24] Contribution of WFP.

[25] Contribution of UNFPA.

D. Prioritization and resource mobilization for maternal health

33. Canada, Germany, Norway and Sweden have included maternal health in their development cooperation programmes. Germany has, for example, launched a rights-based initiative on family planning and maternal health, providing education and capacity-building for midwives and medically trained personnel to provide skilled attendance at delivery. States, including Bangladesh, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Kyrgyzstan, Malawi, Niger, Pakistan, Rwanda, Sierra Leone, Sri Lanka, Tajikistan and Yemen, in addition to the Caribbean Community, the East African Community, the Economic Community of West African States and the Economic and Monetary Community of Central Africa are earmarked as beneficiaries under this programme.

34. The Maternal Health Thematic Fund, which is managed by UNFPA, has supported 43 countries in training human resources for health, in particular midwives, which is essential to addressing maternal mortality and morbidity. The Campaign to End Fistula provided support to more than 50 countries in the prevention, treatment and social reintegration of women and girls suffering or recovering from obstetric fistula.[25] Furthermore, the World Bank, UNICEF, USAID and the Government of Norway made additional commitments of $1.15 billion to improve maternal and child health. The funds will be utilized over the next three years to accelerate progress on Goals 4 and 5 of the Millennium Development Goals and to target developing States having the highest burden of maternal and child deaths.

E. Accountability for progress in reducing maternal mortality and morbidity

35. Member States launched major accountability initiatives including the establishment of national committees to investigate cases of maternal mortality and coordinate perinatal audits (Argentina); confidential enquiry into maternal deaths (Latvia); near-miss case review methodologies (Netherlands); and development of recommendations for medical institutions, medical staff associations and policymakers (Philippines).

36. The Commission on Information and Accountability for Women's and Children's Health provides recommendations for improved tracking of commitments under the Global Strategy for Women's and Children's Health and issued 10 recommendations, which underpin the accountability framework of the Every Woman Every Child movement. Following the Global Strategy and the recommendations of the Commission, an independent Expert Review Group was created to monitor and report on challenges and the progress made, and provide country-level analyses. Recommendations from the Independent Expert Group included the strengthening of global governance and investment frameworks, the development of human rights-based tools, the strengthening of national data collection systems and capacity-building of evaluation bodies at national level.[26] Some of the remaining challenges include strengthening the accountability of States,

[26] WHO, *Every Woman, Every Child* (see footnote 16 above), p. 68.

the integration of reproductive, maternal, newborn and child health services, HIV and malaria treatment services, and the harmonization of funding across initiatives.[26] In addition, the Health Four Plus Partnership developed a global action plan to follow-up on the recommendations of the Commission.

37. A maternal death surveillance and response system that includes maternal death identification, reporting, review and response can provide the essential information for the measurement of maternal mortality and inform actions to prevent future maternal deaths and strengthen national civil registration and vital statistics. New guidance developed by WHO, UNFPA, the Centers for Disease Control and Prevention and the Department for International Development classify maternal death as a notifiable event and encourage the establishment of maternal mortality review committees. UNICEF, in collaboration with the Department for International Development, launched an initiative on maternal and perinatal death inquiry and response in India, to identify the personal, familial, sociocultural, economic and environmental factors that contribute to maternal deaths. Implementation of the project has resulted in the establishment of referral systems, helplines and an increase in the number of institutions that can conduct safe deliveries.

F. Data and knowledge on maternal mortality and morbidity

38. Obtaining accurate data on maternal mortality is a challenge even where reliable civil registration and vital statistics systems exist. In those situations, the pregnancy status of a woman may be overlooked in the classification and coding of the cause of death, especially in early pregnancy or in the immediate post-partum period. For countries without reliable and complete vital registration systems, indirect methods of estimation are used to derive estimates of maternal mortality. The Maternal Mortality Estimation Inter-Agency Group and an independent technical advisory group regularly produce estimates and updates of maternal mortality for all countries, drawing on existing data.[27] However, vital registration systems backed by accurate cause-of-death certification, can significantly improve the quality of available data. Of the over 100 countries that do not have reliable vital registration systems, three quarters are in sub-Saharan Africa and South-East Asia, where maternal mortality and morbidity are high.[28] Only 1 out of 75 high-burden maternal mortality countries, as identified by the Every Woman Every Child movement, have data on the 11 core maternal and child health indicators adopted by the Commission on Information and Accountability for Women's and Children's Health under the Global Strategy for Women's and Children's Health, while the majority of the countries have little available data.[29] In its 2013 publication, the Independent Expert Review Group called for increased advocacy and investment in national civil registration and vital statistics systems and the convening by the United Nations of a high-level working group to address the issue.

---

[27] Members include WHO, UNICEF, UNFPA, the United Nations Population Division and the World Bank.

[28] Civil Registration and Vital Statistics, available from: http://portal.pmnch.org/downloads/high/KS17-high.pdf (accessed 31 October 2013).

[29] Independent Expert Review Group, *Every Woman, Every Child: from Commitments to Action — The First Report of the Independent Expert Review Group on Information and Accountability for Women's and Children's Health* (Geneva, WHO, 2012).

39. In recent years, much progress has been made with regard to specific service delivery indicators. Many developing countries continue to participate in data collection efforts by Measure Demographic and Health Surveys, which provide a wealth of information on issues such as delivery care and antenatal care. As a result of this and other efforts, data on skilled birth attendance has improved and is available for the past five years for 145 countries, compared with fewer than 80 countries in the preceding five years and fewer than 10 countries in the 1990s.[30] Uganda has strengthened its data collection system through the introduction of a mobile vital record system, which was supported by Uganda Telecom and UNICEF.

40. Two key developments in data collection and analysis include the establishment of the Inter-agency and Expert Group on Gender Statistics to provide guidance on the inclusion of gender-responsive indicators and analysis, and the recommendation by the Commission on Information and Accountability for Women's and Children's Health to integrate equity dimensions such as wealth, sex, age, maternal education, ethnicity and urban/rural residence into national data collection strategies. According to the International Telecommunication Union, another innovation relates to the expansion of the use of an e-health mobile platform for birth registration, and maternal and child health information by midwives and health workers.

VI. Major global initiatives

41. Global initiatives are important in mobilizing key stakeholders to focus on critical priorities for maternal mortality and morbidity, creating platforms for increased funding, and developing and disseminating innovative strategies.

42. The Every Woman Every Child movement is a major catalyst for the mobilization and intensification of national and international actions to improve the health of women and children globally, aiming to save 16 million lives by 2015 in the 49 poorest countries. It puts into action the Global Strategy for Women's and Children's Health. Achievement of the Global Strategy necessitates $88 billion in investments — estimates indicate that by 2010 $40 billion to $45 billion had been mobilized, with approximately $18 billion to $22 billion being new and additional financing.[31] As at June 2013, 293 stakeholders had committed to the Global Strategy, and an estimated $25 billion has been disbursed to date, an increase from the previous year. For the past two years, family planning has received the largest number of commitments to the Global Strategy.[32]

43. In support of the Every Woman Every Child movement, a number of partnership initiatives have been established. The Global Investment Framework for Women's and Children's Health, developed by the Partnership for Maternal, Newborn and Child Health and WHO, provides guidance on resource allocation to maximize social and economic returns. In order to bring global attention to critical

[30] World Bank and Women Deliver, "Closing the deadly gap between what we know and what we do: investing in women's reproductive health", p. 19.

[31] Independent Expert Review Group, *Every Woman, Every Child* (see footnote 16 above), p. 27.

[32] WHO and The Partnership for Maternal, Newborn and Child Health, *The PMNCH 2013 Report. Analysing Progress on Commitments to the Global Strategy for Women and Children's Health*, available from http://www.who.int/pmnch/knowledge/publications/pmnch_report13.pdf (accessed 15 October 2013).

and underresourced areas, such initiatives as the United Nations Commission on Life-Saving Commodities for Women and Children, Family Planning 2020 and A Promise Renewed were launched in 2012.

44. The Health Four Plus initiative, as a part of the Every Woman Every Child movement, focuses on strengthening linkages among interventions at the country and international levels, mobilizing strong political commitment, providing a robust framework for monitoring and evaluation. United Nations entities work jointly to support countries to develop national health plans aligned with the Millennium Development Goals; mobilize resources; address the needs of health workers, tackle the root causes of maternal mortality and gender inequality; and strengthen data collection. The partnership is becoming a "one-stop-shop" for countries to access technical and financial support for the entire spectrum of reproductive, maternal and child health. Donors such as Canada, France and Sweden consider the partnership as a valuable platform to operationalize their support.[32] At the country level, entities have successfully mobilized resources to support the implementation of Health Four Plus joint plans in 19 countries in support of Member States to implement national health plans related to sexual, reproductive and child health.[33] In 2012, the High Burden Country Initiative was launched to provide an in-depth assessment of the midwifery workforce in eight priority countries.

45. The Muskoka Initiative: Maternal, Newborn and Under-Five Child Health supports national efforts to address maternal and child health challenges and to accelerate progress towards the attainment of Goals 4 and 5 of the Millennium Development Goals. States benefiting from this initiative include Afghanistan, Bangladesh, Ethiopia, Haiti, Malawi, Mali, Mozambique, Nigeria, South Sudan and the United Republic of Tanzania.

46. The Millennium Development Goals Acceleration Framework has developed action plans in over 50 countries to analyse bottlenecks, consolidate efforts for the greatest impact and align partner initiatives. Plans focused on maternal health were the most commonly developed owing to the slow progress being made under Goal 5.[34]

47. The Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive: 2011-2015 contributes to the elimination of maternal mortality. The Global Plan has established specific targets for the treatment of pregnant women living with HIV to ensure that they are kept alive in 22 priority countries with the highest estimates of pregnant women living with HIV. Funding for the Global Plan is provided by the United States President's Emergency Plan for AIDS Relief, the Bill and Melinda Gates Foundation, Chevron Corporation and Johnson and Johnson.

48. The United Nations Inter-agency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children is the operational arm of the Global Plan, focused on developing the strategic framework on preventing HIV and unintended pregnancies to assist health providers in delivering interventions to reach the target of a 50 per cent reduction of AIDS-related maternal deaths in 22 priority countries.

---

[33] WHO, *The H4+ Partnership* (see footnote 22 above), p. 22.

[34] UNDP, "Accelerating progress, sustaining results: the MDGs to 2015 and beyond" (2013).

49. Saving Mothers, Giving Life, a partnership between the Governments of the United States and Norway, and private sector and non-governmental organizations, invests in the health of women and the elimination of maternal mortality in 10 countries over a five-year period. The Healthy Baby, Healthy Mama programme in Uganda and Zambia has established medical facilities, trained community health workers and conducted extensive awareness-raising, which has resulted in a greater number of women opting to utilize antenatal care services and safe deliveries.[35]

50. Civil society organizations have contributed to developing human rights-based approaches and programmes. The International Initiative on Maternal Mortality and Human Rights and the University of Essex Human Rights Centre (United Kingdom), the Asian Forum of Parliamentarians on Population and Development and the Center for Reproductive Rights have issued guidance documents and tools to develop interventions on maternal health, based on a human rights framework. They have engaged in advocacy at the global and national levels with the aim of making States more responsive to and accountable for maternal mortality and morbidity.

51. Building on the partnerships, commitments and networks developed through their conferences, Women Deliver promotes investment in the health of women, focusing in particular on the elimination of maternal mortality and the general improvement of the lives of women and girls. During 2012, Women Deliver held regional consultations on Goal 5 and the post-2015 development framework with leaders and experts in Africa, Asia, Latin America and the Caribbean.

VII. Conclusions and recommendations

52. Actions have been taken to strengthen linkages among interventions for gender equality, the empowerment of women and girls, and the elimination of preventable maternal mortality and morbidity. This is evidenced by the work of individual Member States, the Health Four Plus partnership and other collaborative efforts undertaken by United Nations entities and other global partners. The efforts have led to greater mobilization of resource commitments, increased collaboration and accountability for progress, and increased interventions addressing the human rights of women and the root causes of maternal mortality.

53. Understanding and acknowledgement of the importance of human rights-based approaches and the root causes of maternal mortality and morbidity have increased at the global and national levels. However, limited information and analysis have been provided on the implementation of particular interventions with a human rights-based approach that address the root causes of maternal mortality and morbidity, the effectiveness of such interventions and the allocation of sufficient resources to that end.

54. Timely, concerted action is needed to accelerate the elimination of maternal mortality and morbidity, reduce by 75 per cent maternal mortality ratios and achieve universal access to reproductive health. Despite significant progress, maternal mortality and morbidity ratios remain high within many countries and subpopulations around the world. As the 2015 deadline for achieving the Millennium Development Goals approaches, countries with high maternal mortality and morbidity ratios are at

[35] Saving Mothers, Giving Life, “External evaluation of Saving Mothers, Giving Life”, Final Report (October 2013).

risk of missing the mark. Efforts should continue not only to strengthen the response of the health sector but also to ensure that the key principles of gender equality and women's empowerment are integrated into responses at all levels.

55. Within the discussions on the post-2015 development agenda there is an additional opportunity to include gender-responsive approaches and address the root causes of maternal mortality and morbidity within the broad framework that promotes gender equality and women's empowerment.

56. **The Commission on the Status of Women may wish to encourage Member States to:**

(a) **Urgently intensify actions, in collaboration with all stakeholders, to further reduce maternal mortality and morbidity within a gender equality framework;**

(b) **Eliminate structural barriers to the enjoyment of reproductive health, including discriminatory social norms, the exclusion of women from decision-making and lack of access for women and girls to resources;**

(c) **Address the root causes of maternal mortality and morbidity through legal and policy frameworks and programmes in the areas of poverty, inequality, gender-based violence, education, women's participation in decision-making and women's economic empowerment;**

(d) **Adopt and implement laws to protect women and girls from violence and harmful practices, including child, early and forced marriages;**

(e) **Adopt and implement fully funded multisectoral national action plans that include specific targets, timelines, monitoring and evaluation mechanisms, as well as activities to address the reduction of maternal mortality and morbidity and the special needs of vulnerable groups of women;**

(f) **Strengthen national accountability measures by engaging civil society organizations, including women's groups, to actively participate in the promotion and protection of women's and children's health;**

(g) **Adopt gender-sensitive social protection measures to support women and girls in accessing reproductive and other health services;**

(h) **Increase the accessibility of affordable and quality health services, including family planning, antenatal and postnatal care, and skilled delivery and emergency obstetric care, and integrate HIV/AIDS and malaria prevention, care and treatment interventions into such services, particularly for young and unmarried women, and vulnerable groups of women and girls, including during humanitarian crises and armed conflict;**

(i) **Establish fully functional national health information systems, including civil registration and vital statistics systems, as well as emergency obstetric care needs assessments, and maternal death surveillance and response systems; and integrate core maternal mortality and morbidity health indicators into existing health information systems, as recommended by the Commission on Information and Accountability for Women's and Children's Health;**

(j) **Engage, through educational programmes and awareness-raising activities, communities, religious and traditional leaders, men and boys as a**

means of encouraging responsible sexual and reproductive health behaviour and sharing the responsibility for the elimination of maternal mortality and morbidity with the overall goal of promoting gender equality;

57. **The United Nations system and other international, regional organizations are encouraged to:**

(a) **Continue to support Member States, in collaboration with other stakeholders, in achieving the following:**

(i) **Urgent intensification of actions to further reduce maternal mortality and morbidity;**

(ii) **Adoption of laws and policies to address the root causes of maternal mortality and morbidity;**

(iii) **Increased accessibility of health-care services, including reproductive health services;**

(iv) **Establishment of national health information systems to monitor and evaluate laws, policies and programmes addressing maternal mortality and morbidity;**

(b) **Continue to work through collaborative initiatives with civil society organizations and other stakeholders towards elimination of maternal mortality and morbidity, and develop robust coordination, accountability and technical knowledge platforms with a view to expanding joint interventions in additional countries;**

(c) **Continue to provide informed views and analysis on the need for the adoption of a human rights-based approach to addressing maternal mortality and morbidity.**