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ADVANCING SAFE MOTHERHOOD THROUGH HUMAN RIGHTS

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Foreword

It is well over a decade since the World Health Organization (WHO) and its partners launched the Safe Motherhood Initiative to help reduce the severe burden of pregnancy-related illness and death affecting so many women around the world. One of the key lessons learned during this time has been that whereas safe motherhood is critically dependent on the provision and use of good quality reproductive health care, it must also involve strategies to empower women so that they have access to education and information, to employment and to other resources. In brief, achieving safe motherhood means fulfilling the human rights of women.

Health system interventions such as the provision of essential and emergency obstetric care are crucial to the reduction of maternal mortality and morbidity. Such interventions fall squarely in the domain of an international health agency such as WHO. These interventions cannot, however, be implemented without taking account of the host of social factors affecting pregnancy-related illness and death. Health services may be very far away with no transport available, or they may simply not exist. If they are reachable, a pregnant woman may not be able to decide to go there without her husband's permission, or she may not be allowed to travel on her own. She may not know that swollen ankles, vaginal bleeding or feeling giddy are signs for which she should seek professional advice. Or she may simply not be able to pay for professional health care. These factors often result from women's poor status in society, and from laws, policies and practices that hinder rather than promote their rights.

We believe that the essential health sector interventions can be strengthened by using the principles and tools of human rights. This may involve reviewing and modifying laws and policies so that they protect women's health interests; but it will also mean ensuring that health services and information are provided in a way that respects human rights.

This is a complex field – one which requires a joining of the disciplines of medicine and public health with that of law. In this paper, the authors lay out a framework for bringing together human rights and reproductive health so that the one may serve the aims of the other. "The ideal that women should exercise free choice in maternity and survive pregnancy and childbirth is modest," they state, "but fundamental to the human dignity of women and to the building of families and societies on principles of justice." For all of us who are working towards this ideal, *Advancing Safe Motherhood through Human Rights* is offered as an important contribution for debate and action.

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Executive summary

This report considers how human rights laws can be applied to relieve the estimated 1,400 deaths world-wide that occur every day, an annual mortality rate of 515,000, that women suffer because they are pregnant. Human rights principles have long been established in national constitutional and other laws and in regional and international human rights treaties to which nations voluntarily commit themselves. The intention of the report is to facilitate initiatives by governmental agencies, nongovernmental groups and, for instance, international organizations to foster compliance with human rights in order to protect, respect and fulfil women's rights to safe motherhood.

The report outlines how the dimensions of unsafe motherhood can be measured and comprehended, and how causes can be identified by reference to medical, health system and socio-legal factors. It introduces human rights laws by identifying their sources and governmental obligations to implement them, and explains a range of specific human rights that can be applied to advance safe motherhood. The rights are shown to interact with each other, and for purposes of discussion, they are clustered in the following ways:

- rights to life, survival and security,
- rights relating to maternity and health,
- rights to nondiscrimination and due respect for difference, and
- rights to information and education relevant to women's health protection during pregnancy and childbirth.

The setting of performance standards for monitoring compliance with rights relevant to reproductive health, and availability and use of obstetric services are addressed. In conclusion, the report considers several strategies to encourage professional, institutional and governmental implementation of the various human rights in national and international laws relevant to reduction of unsafe motherhood, and to enable women to go through pregnancy and childbirth safely.

I. Introduction

Every year worldwide, an estimated 515,000 women die of complications of pregnancy and childbirth,[1] a rate of over 1,400 maternal deaths each day. At least 7 million women who survive childbirth suffer serious health problems, and a further 50 million women suffer adverse health consequences after childbirth.[2] The overwhelming majority of these deaths and complications occur in developing countries. Most of the deaths and some of the severe complications could be prevented by cost-effective health interventions.[3] The probability of maternal death faced by an average woman over her reproductive life-span varies from 1 in 7 women in Ethiopia, to 1 in 130 in Brazil, to 1 in 90 in the Philippines, to 1 in 8,700 women in Canada (see Appendix 1). Globally, maternal mortality ratios present the largest discrepancy in any public health statistics between developed and developing countries.[4]

States have made legal and political commitments to protect the health of women, children and families through different human rights (see Appendix 2), expressed through their national laws and membership in international human rights treaties (see Appendix 3). In many cases, however, the tragic reality of high levels of preventable maternal mortality remains. Further, the likelihood to survive pregnancy and childbirth or to succumb to maternal death varies greatly not only between rich and poor countries, but also between rich and poor women within countries.[5] Differential survival rates indicate international and internal national injustices.

Purpose

The purpose of this discussion document is to explore how human rights, long established in national constitutional laws and other national laws, and international human rights treaties, can be applied to advance safe motherhood. The intention is to contribute to national initiatives to promote compliance with human rights principles, and national and international dialogues on how a human rights approach to advance safe motherhood might be developed and applied.

The document is intended as one step in a series of steps to assist collaboration between health care providers with knowledge of the problems of maternal mortality and morbidity, and actors committed to achieving compliance with human rights. These include governmental officers and human rights advocates working, for instance, with health professional organizations and nongovernmental organizations (NGOs).

The Significance of Human Rights

Understanding of human rights begins with a sense of injustice. Claims to remedy injustice are often expressed as human rights claims. A human rights agenda might at first appear a remote ideal. In fact, most human rights agendas are founded on modest and immediate claims that individuals make to remedy the injustices they face in their own lives. The language and particular concepts of human rights have been developed through the struggles of individuals to correct the wrongs that they encounter.

The laws under which people live are frequently unfamiliar to them. Legal institutions such as legislatures, courts and tribunals and human rights commissions, are distant and inaccessible. Legal officers, such as judges and lawyers, can be intimidating. However, laws, legal institutions and legal officers all owe duties to respect, protect and fulfil human rights that are becoming progressively enforceable. By invoking human rights, individuals can legitimately demand the attention and respect of legal institutions and officers, and bridge the gap between law and its application.

Human rights are rooted in historic, prestigious and authoritatively endorsed national constitutions and laws, and international treaties and documents. Many individuals find human rights empowering because they provide means by which individuals can legitimately assert their interests. Governmental agencies can employ human rights to advance social justice among the people they lead and serve, and individuals and groups can employ human rights to require governmental agencies to observe the standards of conduct to which they have committed themselves. Human rights, expressed in national and international laws, are tools that direct government agencies, individuals and institutions towards the appropriate shaping of their own policies and practices, and equip them with the principles and language to urge improvements in the policies and practices of others.

An enduring challenge in advancing human rights is the lack of understanding of how to invoke human rights to prevent wrongs, and, when wrongs have occurred, to remedy them through the application of human rights. Those who are unfamiliar with the language of rights may characterize human rights as an alien intrusion on national sovereignty. Nevertheless, most states have national constitutions and many states have subscribed to regional and international human rights treaties. These constitutions and human rights treaties can be applied to protect women against discrimination and neglect of their basic health needs.

In the deprived environments in which many women live, some find the apparently lofty ideals to which human rights appeal to be unrealistic to improve their circumstances or protect them against the neglect of their basic health care needs. The modern flame of human rights arose, however, out of the ashes of despair, helplessness and genocide. The challenge is to create a better future by applying human rights principles so that all women can live in dignity and health. The ideal to avoid preventable deaths and to ensure healthy lives to women and their families underlies the human rights contained in the constitutions upon which nations plan their futures, and in international treaties designed to make respect for human rights universal.

Human Rights Approaches to Safe Motherhood

There are many human rights that, taken alone and in combination with others, serve safe motherhood. Human rights can be applied to remedy disadvantages that predispose women to vulnerability in pregnancy, such as devaluation and neglect of girl children that result in their malnutrition and anaemia. Fulfilment of human rights relating to education and employment can help to provide girls with education and employment opportunities. Education and employment, in turn, will help girls

and young women to achieve sufficient independence to exercise choice about when to marry, to select and use appropriate contraceptive methods, and to gain access to maternal health services.

The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times. A human rights approach shows that women's maternal mortality and morbidity result not simply from their disadvantages but frequently from cumulative denials of their human rights; that is, failure to address their preventable death and sickness is a result of injustices that women experience. A human rights approach to safe motherhood identifies forums to acknowledge the wrongs women suffer through the neglect of their basic health care needs as denials of their human rights, and seeks means by which these denials can be remedied.

Health care providers who are aware of their patients' and their own human rights can undertake their clinical and administrative responsibilities in ways that protect and promote these rights, and employ human rights claims in negotiating with their institutions, communities and governments on behalf of women's rights to safe motherhood. A human rights approach allows health care providers and administrators to:

- participate with colleagues in their own, related and different fields in determining how best to advance safe motherhood through human rights;
- understand how laws, policies and practices conform to women's rights to safe motherhood;
- determine which human rights might be more effectively implemented in order to advance safe motherhood; and
- encourage governments to keep their promises to respect, protect and fulfil human rights relevant to safe motherhood.

Challenges and Opportunities

There is no comprehensive list of obstacles to achieving respect for human rights, but major challenges to safe motherhood focus on:

- The rights of women. The historic promotion of The Rights of Man has left the rights of women a marginal or subordinate concern. The absence, and sometimes exclusion, of women from leading agencies of social reform has deprived human rights developments of women's voices and experiences.

- The right to health. The movement for human rights has focused more on the right to survival against oppression than to the quality of life, to which health is central. Maternal death has been accepted as part of the natural order, rather than as an avoidable consequence of women's ill health resulting from unjust disadvantage.

- The rights of the poor. The burden of unsafe motherhood is borne predominantly by women in poor families, communities and countries. Poor people generally lack access to public provision of health services, and to legal systems to remedy this injustice.

While the list of challenges could be lengthened, the list of opportunities to overcome challenges is growing. Within countries, there is gathering momentum for administrative health sector reform to achieve justice in health resource allocation, and increasing activity through national courts to address women's rights in general and rights to basic health services in particular. Internationally, there have been important developments through UN conferences and agencies, treaty monitoring bodies and human rights tribunals to promote women's equality and rights regarding health care. The challenge to frame effective remedies for unsafe motherhood is profound, because the causes are complex and multifaceted. However, national and international initiatives on safe motherhood have identified promising interventions on which wider programmes for relief and eventual remedy might be founded.

The ideal that women should exercise free choice in maternity and survive pregnancy and childbirth is modest, but fundamental to the human dignity of women and to the building of families and societies on principles of justice. The challenge to human rights principles is to make the promise of safe motherhood real. The opportunity of advancement through ensuring respect for human rights has been recognized nationally and internationally, and the language of human rights has come to define the best enjoyments of life that countries can offer their populations.

Overview

Part II of this discussion document, Understanding Safe Motherhood, provides an overview of the scope and context of maternal death and disability. It surveys the sources of knowledge on unsafe motherhood from its epidemiological dimensions, the medical causes, health system laws and policies and the underlying socio-legal conditions. The section ends by explaining that since medical causes, risk factors and underlying socio-legal conditions may vary from country to country, and even possibly from community to community within a country, a local assessment is a desirable first step in applying human rights to advance safe motherhood.

Part III, Human Rights Affecting Safe Motherhood, reviews the sources of human rights in national laws, and regional and international human rights treaties. It identifies the different obligations that governments bear to implement human rights in order to ensure compliance with national laws and commitments under human rights treaties. It addresses how the following categories of rights could be applied to relieve causes of maternal mortality and morbidity:

- rights relating to life, survival and security of the person;
- rights relating to maternity and health;
- rights to non-discrimination and due respect for difference; and
- rights relating to information and education.

Human rights may be applied, individually and collectively, to advance safe motherhood. Rights are rarely expressed, however, in language that is directly applicable to reproductive health. As a result, one needs to draw on national court decisions, documents of international authority and guidance of treaty monitoring

bodies to show how rights have been, and could be, applied to protect and advance reproductive health interests. The challenge of promoting safe motherhood is to achieve collaboration among colleagues who can bring their individual knowledge of medicine, health care, social science, local culture and community practice, governmental structure and law to the task. The relevance of a particular right to an alleged failure of reproductive and maternal health must be shown. Accordingly, health care providers who seek improved compliance with human rights affecting safe motherhood may bear an initial burden of persuasion to show how such rights have been neglected.

Part IV, Strategies for Implementation, addresses strategies for the application of human rights to ensure free choice of maternity, provision of and access to health services and achievement of enabling conditions necessary for safe motherhood. These strategies include:

- education and training to reinforce safe motherhood as a human right;
- negotiation for improved services and enabling conditions; and
- implementation of accountability for safe motherhood at national, regional and international levels.

The strategies range from using education, which is the least adversarial approach, to the more adversarial approaches of procedures to enforce accountability. Each strategy will assist in assessing remedies that might be effective to address unsafe motherhood and its causes, determining the agencies that are bound to provide remedies, and identifying the procedures that are available at domestic, regional and international levels to foster compliance with human rights. A human rights approach to the remedy of violations requires the specification of an appropriate outcome and the available procedures inspired by human rights principles to secure that outcome.

II. Understanding Unsafe Motherhood

A sequence of three events explains unsafe motherhood:

1. a woman becomes pregnant, voluntarily or involuntarily;
2. she suffers one or more complications caused or aggravated by pregnancy and/or childbirth; and
3. the complications are not treated or are not treated properly.[6]

Understanding the risk factors that contribute to these events and the different intervention points that might reduce the risk factors is a necessary first step in developing a strategy for advancing safe motherhood through human rights.

The Committee on the Elimination of Discrimination Against Women (CEDAW) was established through the UN Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)[7] to monitor the Convention's application. CEDAW has issued a General Recommendation on Women and Health (see Appendix 4) that explains how different kinds of risk factors may differ for women and men. These factors include:

- biological factors that vary between women and men according to their reproductive functions, such as pregnancy and childbirth;

- socio-economic factors that can vary according to sex, race and age, such as widely prevalent marriages of adolescent girls;

- psycho-social factors that can vary according to sex, such as postpartum depression; and

- health system factors such as maintaining legal and practical obstacles to access to services and denying confidentiality when women seek services. (see Appendix 4, para 12)

In some communities, inequality of girl children and women is the transcending risk factor that explains the prevalence not only of maternal mortality and morbidity, but also of higher vulnerability of girls to childhood mortality.[8] Risk factors like malnutrition of girl children resulting in anaemia, and early marriage resulting in premature pregnancy, can be traced to the fact that women do not enjoy the status and significance in their communities that men enjoy.

Understanding of the specific risk factors for unsafe motherhood in a country or a community can be gained through knowledge of epidemiological dimensions of ill-health, the particular distribution of medical causes, the health system factors and the underlying socio-legal conditions.[9] These risk factors may vary from country to country, and even possibly from community to community within a country. Exploration must proceed incrementally, first assessing the scope and context of maternal death and disability in a given country or region, and then considering critical explanations of different conditioning factors from which deaths and disabilities result.

A. Maternal Mortality and Morbidity

Public health research will measure the maternal health status of a population through a variety of statistically based methods including routine surveillance, household surveys and epidemiological studies.[10] Past attempts at measuring the health burden related to pregnancy and childbirth have focused primarily on measures of mortality. 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."[11]

The following measures are used in describing maternal mortality:

> **"Maternal Mortality Ratio:** (number of maternal deaths per 100,000 live births): This measure indicates the risk of maternal death among pregnant and recently pregnant women. It is a measure of obstetric risk and a reflection of a woman's basic health status, her access to health care, and the quality of service that she receives.
>
> **Maternal Mortality Rate:** (number of maternal deaths per year for every 100,000 women aged 15-49): This measure reflects both the risk of death among pregnant and recently pregnant women, and the proportion of all women who become pregnant in a given year. It therefore can be reduced either by reducing obstetric risk (as is true for the ratio, above) and/or by reducing the number of pregnancies.
>
> **Lifetime Risk:** This measure reflects the probability of maternal death faced by an average woman cumulated over her entire reproductive life-span. Like the maternal mortality rate, it reflects both a woman's risk of dying from maternal death, as well as her risk of becoming pregnant in the course of a reproductive lifetime. [see Appendix 1]
>
> **Proportionate maternal mortality:** (number of maternal deaths as a proportion of all deaths among women of reproductive age): This figure represents how important maternal mortality is as a cause of death among women of reproductive age."[12]

A general source of national maternal mortality statistics is the WHO/UNICEF/ UNFPA 1995 estimates of maternal mortality.[13] This source draws on a wide range of available data and statistical modelling to provide estimates of maternal mortality for all countries of the world.

In addition to the numbers of women who die of pregnancy related causes, there are many more who suffer from one or more of a wide array of maternal morbidities. "Maternal mortality is frequently described as 'just the tip of the iceberg,' implying that there is a vast base to the iceberg – maternal morbidity – which remains largely undescribed."[14] However, maternal morbidity is difficult to define, interpret and measure. Maternal morbidity has many dimensions: origin (etiology), severity,

duration, time of onset, accumulation and sequelae. Each has different contributory causes, consequences and implications for treatment.[15] Hence, maternal morbidity is unlikely to replace maternal mortality as a measurement of the scope of the problems relating to unsafe motherhood in a given community or region.[16]

Maternal mortality is also difficult to measure. In countries with complete vital registration, the attributed cause of death gives information about maternal mortality. Nonetheless, misclassification of maternal deaths can arise for a variety of reasons.[17] Other countries may have relatively complete vital registration in terms of number of deaths, but the cause of death may frequently be inadequately classified. Cause of death is routinely reported for only 78 countries or areas, covering approximately 35% of the world's population.[18] Most of the developing countries of the world – and all of those where levels of maternal mortality are very high – have no reliable system of vital registration, and maternal deaths go largely unrecorded.[19]

Where medical certification of cause of death is not available, other techniques such as verbal autopsy can be used. Verbal autopsy is "a method of finding out the medical causes of death and to ascertain the personal, family or community factors that may have contributed to the death in women who died outside of a medical facility". [20] It consists of interviewing people who are knowledgeable about the events leading to the death. This technique provides information beyond the immediate cause of death, which can point to possible interventions to prevent similar situations in the future.

More recently, several other methods have been developed to assist health workers investigate maternal deaths and severe complications of pregnancy. One of these, the Maternal Death Case Review (MDCR), is "a qualitative, in-depth investigation of the causes and circumstances surrounding maternal deaths occurring at health facilities. It is particularly concerned with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable".[21] The process is aimed at improving quality of care by identifying not only causes of sub-standard care but also community factors which contributed to the death. Based on these findings, a consensus is built around what interventions would be most effective in remedying their causes.

A more elaborate technique is the Confidential Enquiry into Maternal Deaths. This has been defined as an investigation "undertaken by multi-professional teams, which identifies weakness and deficiencies in the maternal healthcare system. It investigates individual maternal deaths, with the cooperation of all those involved in the care of the patient, yet removes all identifying details from individual case reports to ensure that information is used only for making recommendations for positive practice changes and not for punitive action".[22] Unlike the MDCR, the Confidential Enquiry is usually undertaken at national level.

Self-reporting may provide another source of maternal health information. For instance, the home-based maternal record takes the form of a report card, and depends on mothers at home recording information about their pregnancies, the births of their children, and health problems between pregnancies.[23]

The aim of this discussion is to provide an overview of the kinds of data that might be available in a given setting to target factors in unsafe motherhood that might be remedied through the application of human rights. The discussion is by no means exhaustive, and those working to advance safe motherhood through human rights will need to refer to the bibliographical literature and websites for sources of more comprehensive information (see Appendix 5). Each data source has limitations, and no single source will offer a complete and reliable picture of unsafe motherhood. As a result, different sources and approaches need to be explored, related to the setting and resources available.[24]

B. Causes

Once the scope of the problem of maternal mortality and morbidity has been considered, the causes of the problem in a particular community or region need to be determined. The causes include:

- Medical causes, consisting of direct medical problems, such as excessive bleeding during pregnancy or delivery, or infection, and of indirect pre-existent or co-existent medical problems that are aggravated by pregnancy, such as anaemia or malaria;

- Health systems laws and policies that affect availability, accessibility, acceptability and quality of reproductive health services; and

- Underlying socio-legal conditions, such as lack of enforcement of minimum age of marriage laws, and lack of alternatives to early marriage and childbearing for adolescent girls.

Examination through public health, legal and social science research may show that medical causes, health resources and underlying socio-legal conditions vary according to community.

1. Medical causes

Epidemiological research shows that globally, the five most immediate medical causes of maternal death are: haemorrhage (bleeding) (25%), sepsis (infection) (15%), unsafe abortion (13%), eclampsia (convulsions) (12%) and obstructed labour (8%).[25] Other direct causes of maternal death, including ectopic pregnancy, embolism and anaesthesia-related risks, amount to about 8%.[26] The majority of deaths from the major direct causes are preventable by cost-effective health interventions. However, many of the complications arising from these causes are not necessarily preventable.

The provision of emergency obstetric services has been identified as an important way of addressing these immediate medical causes.[27] It is explained that women

> "in every country and every population develop complications, but women in developing countries are much less likely to get prompt adequate treatment, and are therefore more likely to die."[28]

In addition to immediate medical causes of maternal death, medical research has shown that pregnancy aggravates other diseases such as malaria, anaemia, jaundice, tuberculosis and heart disease. If the woman dies as a result, the death is classified as an indirect maternal death.[29] In developing country settings, studies indicate that 20 per cent or more of all maternal deaths are due to indirect causes.[30] The percentage will vary among countries, depending upon the prevalence and severity of diseases, such as malaria,[31] that are indirect causes of maternal death.

Sometimes, more than one disease or condition is involved in an indirect maternal death; for instance, both anaemia and malaria worsen during pregnancy, and malaria itself may cause anaemia or aggravate an existing anaemic condition.[32] Another contributor to anaemia during pregnancy is malnutrition. High levels of malnutrition in girl children may have serious consequences for their future pregnancies. Malnutrition can cause stunting which will leave the size of the pelvis small. The smaller the pelvis, the greater the risk of obstructed labour.[33]

Severe anaemia impairs resistance to heart failure, shock, and infection, often resulting in death. While less severe anaemia may not cause death directly, it may contribute toward death from other causes. For instance, anaemic women may not tolerate blood loss to the same extent as healthy women; also, following surgery, their wounds may fail to heal properly.[34] In pregnant women with sickle cell anaemia, deaths may result from the effects of embolism, or bacterial infections during the last four weeks of pregnancy, labour and the first week after delivery.[35]

Sexually transmitted infections (STIs) contribute both to infertility and to pregnancy-related complications, such as sepsis, spontaneous abortion, premature birth, stillbirth and congenital infection. For instance, one study found a significant association of chlamydia trachomatis (the most prevalent STI) antibody with tubal infertility and ectopic pregnancy.[36] In some countries, ectopic pregnancy is the leading cause of first-trimester deaths among pregnant women.[37] Ensuring access to information and services geared to preventing sexually transmitted infections in women and men is an important part of making motherhood safer.

Evidence from several studies suggests that, in addition to risks of pregnancy due to pre-existing or coexistent clinical conditions, pregnancy is associated with an increased incidence of domestic violence, including homicide. Studies in India and China have found that women are at an increased risk of violence if they produce a child of the “wrong” sex, that is, a girl.[38] In Matlab Thana, Bangladesh, homicide and suicide motivated by the stigma of rape, pregnancy outside marriage, or dowry problems accounted for almost 6 per cent of 1,139 maternal deaths between 1976 and 1986.[39]

2. Health systems, laws and policies

Research may determine whether laws and policies facilitate or inhibit women’s access to reproductive health care generally and obstetric care specifically. Most systems have core principles of medical law that protect the right to informed and free decision-making by patients, their privacy and confidentiality, the competent delivery of services and the safety and efficacy of products.[40] Systems vary,

however, in the extent to which these principles are applied to reproductive health services, including obstetric care. Moreover, the enforcement of laws that entitle women to obstetric services, that oblige governmental or other agencies to deliver them and to create accountability for their absence, also vary significantly across national boundaries. Laws may make husbands obliged to provide their wives with necessary health care, but are difficult to enforce when families are impoverished.

Laws that obstruct women's access to information and care can function as direct causes of maternal mortality. Preventing access to services are laws that criminalize medical procedures that only women request and that may be indicated to save their lives and health, such as those that govern contraception and abortion. While often tied to social or religious concerns, these criminal laws put women at risk when they prohibit or deter performance of treatment necessary to save the lives of pregnant women. When tested in courts, many of these restrictively worded laws are interpreted to have exceptions where procedures are undertaken in good faith to preserve women's lives or health, but unless so interpreted, their prohibitive language and severe punishments deter physicians from undertaking therapeutic interventions in pregnancy. Laws that prohibit medical procedures but that do not have clearly stated or indeed any exceptions where women's lives or physical and mental health are at risk can be shown to violate human rights requirements.

Some countries have codified laws that entrench women in roles subservient to their brothers and husbands. They require for instance, that women requesting health services obtain their husbands' authorization,[41] or that adolescent girls seeking health services obtain parental authorization,[42] thereby obstructing medically indicated care and placing women and girls at risk. Often, permission is impossible to receive, or women are afraid or embarrassed to seek it.

Systems of health law and policies that restrict women's reproductive choices are usually based on historical connections between sexuality and morality. Many restrictive policies reflect the idea that women's sexuality and access to birth control endanger morality and family security. Legislation against the provision of contraceptive services and means has historically been expressed in terms of preservation of morality. Some national laws still characterize the provision of birth-control information and contraceptives as an offence against morality.[43]

Another dysfunction found in laws and health regulations or policies is that they require unnecessarily high qualifications of health service providers for routine obstetric care. Such laws are often enacted in the belief that they are necessary for women's protection. However, they frequently unduly obstruct care, or make it unavailable because of limits of facilities, personnel or women's financial means to meet unnecessarily high costs.

Women sometimes refuse to seek health services that are available, because they believe that their medical confidentiality will not be sufficiently respected. This may be particularly so in smaller communities where personal relationships among patients and clinic personnel exist in social life outside the clinic setting. Women's perceptions that their confidentiality may be breached might be usefully addressed by ensuring that clinic policies on legal duties of confidentiality are carefully explained to all those seeking health care. Careful training of health professionals on

how to protect confidentiality, both by themselves and by their assistant personnel, particularly in sensitive matters of reproduction and sexuality, will equip them to avoid breaches that occur in good faith or through negligence. Emphasis on professional duties of confidentiality, through professional disciplinary committees and/or courts, would reduce the risk of individual breaches, and also instruct members of professions in their ethical and legal responsibilities of confidentiality. Safe motherhood would be promoted through assuring women that they can trust that reproductive health services will be delivered in professional confidence.[44]

Research may find other deterrents to women, or some sub-groups of women, seeking obstetric services. For example, a study has shown that indigenous women experiencing obstetric complications have refused to go to governmental hospitals for fear of being sterilized postpartum without their consent.[45] Moreover, suspicion and fear of improper practices may persist long after they have been eradicated.

Providers and their professional associations may invoke laws, particularly human rights laws, to advocate for better reproductive health services on behalf of their patients. When resources that patients require are denied, providers are increasingly using human rights principles to make reasonable representations to institutional, governmental, private insurance and other agencies that allocate resources, explaining why such agencies should serve their patients' needs. Human rights laws may thereby operate to strengthen systems of health care.

3. Underlying socio-legal causes

Barriers to improving women's health are often rooted in social, economic, cultural, legal and related conditions that transcend health considerations. Social factors, such as lack of literacy and of educational or employment opportunities, deny young women alternatives to early marriage and early childbearing, and economic and other means of access to contraception. Women's vulnerability to sexual and other abuses, in and out of marriage, increases risks of unsafe pregnancy and motherhood. Social, religious and economic customs become embedded in the law, and historically have been claimed to provide a justification for discrimination against women. Social science and legal research, particularly research that takes a gender approach, has been helpful to understanding how these underlying socio-legal causes affect women's status and autonomy.

A gender approach addresses the critical roles that social and cultural factors, and power relations between women and men, play in promoting or inhibiting health. The technique of gender analysis is

> "to identify, analyse and act upon inequalities that arise from belonging to one sex or the other, or from the unequal power relations between the sexes. These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health. They can also affect the access to and control of resources, including decision-making and education, which protect and promote health, and the responsibilities and rewards in health work."[46]

A gender approach to social science and legal research can help to identify how underlying socio-legal conditions can have positive or negative effects on advancing safe motherhood.

a. Social science research

Social science research provides important means to identify social or behavioural practices that might inhibit, or advance, safe motherhood. Social science research aims at:

- "identifying and defining reproductive health problems by measuring the magnitude and nature of reproductive/sexual behaviour and reproductive ill-health; and
- investigating its determinants and consequences; and
- improving and supporting intervention programs which attempt to prevent or treat reproductive health problems through health, family planning, educational and other services; and
- understanding, informing and influencing the policy, legal or social arena in which reproductive health concerns arise."[47]

Social science research looks beyond "statistical indices, percentages, rates and ratios to identify the underlying social, cultural and behavioural factors."[48] This kind of research affords a more complete understanding of women's experiences of reproductive health and illness. Moreover, it can disclose gaps between rights that governments claim that women enjoy and the reality of neglect of women's rights during pregnancy and delivery.[49]

Social science research can provide insights that explain and resolve inadequacies in communal resources and practices that increase women's risks in pregnancy and childbirth. Research can identify general trends and cause-and-effect relationships for the design of improved programmes that communities are willing to adopt and implement. Health care providers may draw on social science research to suggest how governments might develop more effective safe motherhood strategies, such as including gender-specific health information in national surveys, and conducting more refined programmes to determine and address causes of maternal mortality.

b. Legal research

Legal research analyses laws that affect safe motherhood and the degree to which they are or are not implemented through courts (see Appendix 6), administrative agencies, and, for example ministries of health. Legal research addresses how laws:

- regulate women's health care, such as regarding provider-patient relations;
- affect the allocation of scarce health resources; and
- govern women in their personal, family and public lives.

A gender approach to the law moves beyond "understanding of law as either an instrument of oppression or of liberation," to examine the complexities of the law

"in both the oppression of women, and in its promise for challenging that oppression."[50] Gender-sensitive legal studies explore

> "the ideological assumptions that inform … the ways in which law subordinates women - the complex and subtle forms in which law reinforces deeply gendered assumptions, relations and roles [and the ways in which] legal discourse has constructed women as wives and mothers, as passive and weak, as subordinate and in need of protection…. At the same time, law is a site where these roles and identities have been challenged. It is a site where social reformers and feminist activists have sought to displace previously dominant understandings of women's appropriate roles and identities, and sought to reconstruct women's roles and identities as more full and equal citizens."[51]

Such studies help to provide an understanding of the potential and the limitations of the law to empower women, rather than of the law solely as an instrument for protecting the *status quo* or for seeking social change. Debates about what laws on women's health are, and what they should be, allow communities to explore the contested visions of women's roles and identities in personal, family and public lives.

Research at the national level might show how laws affect women's status in general.[52] There are several comparative law studies that provide information on laws in respective countries and regions.[53] A national review of the legal context of unsafe motherhood must take account of laws that prevent or inhibit women's advancement of their interests as they see them, particularly regarding sexuality, marriage, conception, birth and rearing of their children. Research might show the extent of implementation of laws requiring the provision of maternity services, or show how laws obstruct women's access to services. The review should be wide ranging, and extend beyond matters immediately affecting procreation and service delivery, to include laws associated with risk factors for maternal mortality and morbidity, such as child marriage[54] or lack of education. [55]

Legal research can help to identify how laws advance or compromise women's interests in their personal, family and public lives, with indirect effects on the incidence and safety of maternity. Laws that entrench women's inferior status to men, and interfere with women's access to health services, seriously jeopardise efforts to reduce maternal mortality. These laws take a variety of forms, such as those that obstruct economic independence by impairing women's inheritance, employment or acquisition of commercial loans or credit, but they all infringe on women's ability to make their own choices about their lives and health. Account should be taken of criminal laws that condone or neglect violence against women, and, for instance, of inequitable family, education and employment laws that deny adult women alternatives in life to marriage, or that condition women's self-realization on marriage and motherhood.

Investigation should determine, for instance, whether laws adequately protect women and girls from sexual coercion,[56] including sexual abuse.[57] Studies show that forced first intercourse is prevalent in many communities, reaching as high as affecting 32% of women and girls.[58] Laws that inadequately protect women and

girls from sexual coercion, or from coercion in sexual relations, undermine women's independence and ability to protect themselves from unwanted pregnancies. Laws must be identified and enforced that allow women effective defence or self-defence, and to control the timing and number of their births.

Family law frequently expresses communities' basic cultural values. Cultures resistant to women's equality with men have unselfconsciously perpetuated women's subordination as a 'natural' condition of family life and social order so profoundly as to render women's disadvantage invisible. Laws may provide, for instance, that:

- continuation of family name and identity passes through sons but not daughters;
- family land and property are inherited by sons but not widows or daughters;
- education and training of a next generation are due to sons but not daughters;
- family 'breadwinners' are male but not female; and that
- widowed and divorced men may maintain all of their legal capacities and remarry without prejudice, but widows forfeit deceased husbands' social status and legal entitlements and opportunities, such as to pledge property as security for financial loans to maintain businesses, and divorced women do not regain the status and opportunities they had before marriage, particularly if they have not given birth to children, especially sons.

The cumulative impact of such laws is often that daughters are seen to burden their families, that their deaths in infancy are inconsequential, and that they will remain in the home to serve other family members until marriage. On marriage, they will be obedient to their husbands' families by rendering services and bearing sons. Accordingly, daughters will be liable to be given in marriage, while young, to men they do not choose, have no independent status or means while unmarried, conceive early and often in marriage, obediently protect family, social and cultural values before and in child rearing, and be vulnerable to violence and death if perceived to endanger family honour.

C. Local Assessment

A necessary first step towards applying human rights to advance safe motherhood is an assessment of the scope and causes of unsafe motherhood in a particular community, based on available data sources, or on the collection of relevant new data. Where possible, maternal death should be investigated. A maternal death investigation should establish both medical and non-medical causes of death, and whether the death occurs in a hospital or at home. Several factors may influence the success of a maternal death investigation. It must be made clear that the purpose of the investigation is to find ways to reduce maternal mortality – not to find blame and that the information obtained will be confidential. Ideally, personnel who were not directly involved in the woman's care before her death should conduct the investigation.[59]

Health care providers should bear in mind that collecting data is an important procedure for obtaining information, but is not in itself the goal.[60] Ideally, the data will provide insight into which human rights might be applied to advance safe motherhood in a specific setting. Thus, the use to which providers intend to put information on the extent of maternal mortality and morbidity, and on their underlying causes, should determine data collection efforts and choice of sources and methodologies.

Local assessment should identify laws, including decisions of courts, and policies that facilitate availability of and access to reproductive health services, including maternity services. A determination should be made of the extent to which these laws are actually implemented, and if they are not adequately implemented, of how they might be. Laws and policies that obstruct free choice of maternity, and the availability of and access to services, should also be identified, along with laws that facilitate women's empowerment, and laws that obstruct such empowerment.[61]

III. Human Rights Affecting Safe Motherhood

This section addresses the range of human rights, whether found in national law or in regional or international human rights conventions. These rights can be applied individually or combined with others to advance safe motherhood. In the legal application of human rights, it is important to identify those bound by the legal duty to observe human rights, such as governmental agencies, those working under the authority of government, and those carrying out governmental responsibilities. Human rights not backed by legally enforceable duties remain moral rights, and various agencies, officers and others can be made morally accountable through their moral duties to observe them.

The legal challenge is to find not only the human rights breached in unsafe motherhood, but also the rights that would contribute most effectively to future remedies. For instance, a woman may have suffered because a family member was allowed to veto or frustrate her request for necessary care. A remedy may be approached by ensuring respect for a woman's confidentiality in requesting health care, and in applying human rights to achieve women's economic and social equality in access to health care.

It is helpful to have an understanding of how courts and tribunals have applied a particular human right in the past. This understanding will provide an insight into the potential for success in invoking the right to prevent and remedy a violation causing a maternal death. Human rights have been applied in recent decades at national, regional and international levels to secure women's interests in access to contraception, voluntary sterilization, safe abortion and reproductive health information, and in women's freedom from involuntary sterilization and veto powers over their requests for care. These developments provide promise of the capacity of human rights to advance safe motherhood.[62]

A. Sources of Human Rights

Sources of human rights to advance safe motherhood are found in all national constitutions and in international and regional human rights treaties based on the Universal Declaration of Human Rights, adopted in 1948[63] (see Appendix 2). The Universal Declaration itself was not proposed as a legally enforceable instrument, but it has gained legal acceptance and legal enforceability through a series of international human rights conventions, which are also called treaties, covenants or charters. The primary modern human rights treaty concerning women's rights is

- the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention).[64]

This Convention gives expression to the values implicit in the Universal Declaration of Human Rights, and reinforces the Universal Declaration's two initial legally-binding implementing covenants,

- the International Covenant on Civil and Political Rights (the Political Covenant),[65] and

- the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant).[66]

Similarly derived from the Universal Declaration are:

- the International Convention on the Elimination of All Forms of Racial Discrimination (the Race Convention),[67] and

- the Convention on the Rights of the Child (the Children's Convention).[68]

Regional human rights conventions of legal force also draw inspiration from the Universal Declaration, and they include:

- the European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention),[69]

- the European Social Charter - Revised (the European Charter),[70]

- the American Convention on Human Rights (the American Convention),[71]

- the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador),[72]

- the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (the Convention of Belém do Pará),[73] and

- the African Charter on Human and Peoples' Rights (the African Charter).[74]

Additional documents (see Appendix 2) reflect widespread international consensus on issues of women's health and human rights, notably:

- the Cairo Programme of Action (the Cairo Programme)[75] and the Cairo Plus Five follow-up document[76] developed respectively at the 1994 UN Conference on Population and Development, held in Cairo, and its five year review; and

- the Beijing Declaration and Platform for Action (the Beijing Platform),[77] developed at the 1995 Fourth World Conference on Women, held in Beijing, and its five-year review.[78]

Throughout this discussion document, the international and regional instruments above will be referred to by the short names that follow them in brackets.

Like national constitutions that have constitutional courts to monitor compliance with constitutional provisions, the human rights treaties have monitoring bodies to monitor compliance with treaty provisions. For example, the Women's Convention established the Committee on the Elimination of Discrimination Against Women

(CEDAW), and the Committee on the Rights of the Child (CRC) was established under the Children's Convention to monitor state compliance. The Political Covenant established the Human Rights Committee (HRC) to monitor state compliance, and the Committee on Economic, Social and Cultural Rights (CESCR) was established to monitor compliance with the Economic Covenant. Unlike national courts, however, which act only on the occasions when parties bring cases before them, the treaty monitoring bodies receive reports that treaty member states must submit periodically, usually at three to five year intervals.

Countries that are members of an international human rights convention (see Appendix 3) are obligated to report on a periodic basis to the respective treaty monitoring body to provide information on their national performance.[79] For example, the reporting procedure of the CESCR requires States Parties to file an initial report within two years of the Covenant coming into force and thereafter every five years, or at any other time the Committee deems appropriate.[80] States Parties to the Children's Convention are similarly required to submit reports to the CRC two years after the Convention comes into effect for the state concerned, and every five years thereafter.[81] The Committee on the Elimination of Racial Discrimination (CERD), established under the International Convention on the Elimination of All Forms of Racial Discrimination, requires states to report within one year of their ratification and thereafter every two years and whenever the Committee so requests.[82]

Article 18 of the Women's Convention requires States Parties to submit a report within one year of the Convention going into effect for the state concerned and every four years thereafter, and explains that reports may indicate factors and difficulties affecting the degree of fulfilment of obligations. In the specific area of women's health, 166 ratifying states have committed themselves to report regularly to CEDAW on what they have done to:

> "... take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning ... pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[83]

Once a treaty monitoring committee has considered a country report and any additional information on treaty compliance, and discussed the report with the representatives of the reporting government, it issues Concluding Observations. These Concluding Observations note the achievements of the reporting state to take steps to brings its laws, policies and practices into compliance with its treaty obligations, and the concerns the committee has with lack of compliance.[84]

To assist countries to fulfil their reporting obligations, treaty-monitoring bodies have developed a series of General Recommendations or General Comments (see Appendices 4, 7-9).[85] These explain the content and meaning of duties that arise under treaty articles, and outline the kind of information that treaty bodies find useful to receive in reviewing reporting countries' compliance records. Committees have issued general guidelines for reporting and guidelines that are specific to particular articles. In 1995, for instance, HRC amended its general guidelines for

periodic reports to include, "[f]actors affecting and difficulties experienced in the implementation of the [Economic] Covenant including any factors affecting the equal enjoyment by women of that right."[86] CESCR has stressed the importance of observance of the Economic Covenant's minimum core obligations in its general guidelines for reporting.[87]

With regard to guidance on specific articles of the Women's Convention, the CEDAW General Recommendation on Women and Health requires that:

> "... in order to enable the Committee to evaluate whether *measures to eliminate discrimination against women in the field of health care are appropriate*, States Parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures."(see Appendix 4, para 90) (emphasis added)

This Recommendation stresses that:

> "... [r]eports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture." (see Appendix 4, para 9)

Complaint procedures are available under some of these conventions, such as the Race Convention,[88] or under Optional Protocols to others, such as the Political Covenant[89] and the Women's Convention.[90] These procedures enable individuals or groups of individuals from ratifying countries to bring complaints to the relevant treaty body of alleged violations they have suffered, once they have exhausted available domestic remedies. The decisions of treaty bodies help to develop the content and meaning of rights. A successful complaint can have the effect of requiring governments to change or apply laws or to provide remedies that might benefit individuals as well as groups that are harmed (see Appendix 10).

B. Obligations of Government to Implement Human Rights

Under their national constitutions and regional and international human rights treaties, governments face a variety of obligations, including general obligations that can be applied to particular circumstances, core obligations, and immediate and long-term obligations. The CEDAW General Recommendation on Women and Health (see Appendix 4) and CESCR's General Comment on Health (see Appendix 7) explain that governments have three different kinds of general legal obligations to implement human rights. They are:

- the obligation to *respect* rights, which requires states to refrain from interfering with the enjoyment of rights;

- the obligation to *protect* rights, which requires states actively to prevent violations of human right by third parties; and

- the obligation to *fulfil* rights, which requires states to take appropriate governmental measures toward the full realization of rights.

These obligations are elaborated by treaty monitoring bodies in their development of General Recommendations or General Comments. For example, the CEDAW General Recommendation on Women and Health explains the obligations with respect to Article 12 of the Women's Convention in the following way:

> "The obligation to *respect rights* requires states parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care." (see Appendix 4, para 14)

This General Recommendation explains that states are obliged to change laws or policies that require women to seek the authorization of their husbands, parents or health authorities to obtain health services, because such laws or policies obstruct women's pursuit of their health goals. The Recommendation also states that the Women's Convention may be infringed by "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures." (see Appendix 4, para 14)

The General Recommendation further observes that:

> "The obligation to *protect rights* relating to women's health requires states parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations."(see Appendix 4, para 15)

The Recommendation explains that the duty to protect rights requires the "enactment and effective enforcement of laws that prohibit … marriage of girl children" (see Appendix 4, para 15). The duty of protection also includes responsibility to develop health care protocols and programmes of gender training for health care providers and in the provision of health services, in order to identify, address, prevent and remedy the causes of unsafe motherhood.

The General Recommendation goes on to make clear that:

> "The duty to *fulfil rights* places an obligation on States Parties to take appropriate legislative, judicial, administrative and budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care." (see Appendix 4, para 17)

The General Recommendation explains that studies that show high rates of maternal mortality and morbidity, or large numbers of couples who would like to limit their family size but lack access to contraception, provide important indications about possible breaches of duties to ensure women's access to health care.

In addition to these general obligations, CESCR has issued a General Comment which explains the minimum core obligations of Article 12 on the right to the

highest attainable standard of health (see Appendix 7). This General Comment establishes that states have core obligations to provide essential primary health care in order to satisfy the right to the highest attainable standard of health. The General Comment explains that "core obligations are not subject to resource limitations or progressive realization, instead their realization is required immediately" (see Appendix 7, para 19). The General Comment requires governments at least:

43(a) "to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups;

(b) to ensure access to minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

…

(e) to ensure equitable distribution of all health facilities, goods and services;

(f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of actions is devised, as well as their content, shall give particular attention to vulnerable or marginalized groups;

…

44(a) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

…

(d) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them

(e) to provide appropriate training for health personnel, including education on health and human rights…." (see Appendix 7, para 43-44)

The General Comment explains that immediate obligations with regard to the right to health include the obligation to eliminate health-related discrimination, for example in access to health care, and to take no retrogressive measures with regard to health, including withdrawal of services.

C. The Application of Human Rights to Safe Motherhood

Safe motherhood may be advanced through several specific legally established human rights. The choice of which rights to apply will depend on the immediate and underlying causes of maternal death and ill health.[91] Several human rights may be cumulatively and interactively applied to advance particular interests. The rights addressed below are not exhaustive but are indicative of rights that may be applied to promote safe motherhood. Moreover, the discussion is only suggestive of how

different rights have been or could be applied. As human rights are applied to advance safe motherhood by different countries under their respective constitutions and regional and international human rights commitments, it is hoped that additional ways of applying rights will be developed.

The discussion below will explore how specific rights, clustered around the following categories, might be applied to different factors contributing to maternal death and disability:

- rights relating to life, survival and security of the person;
- rights relating to maternity and health;
- rights to non-discrimination and due respect for difference; and
- rights relating to information and education.

The determination of which rights to apply will depend on:

- how the rights have been applied in the past by national courts, regional and international human rights tribunals (see Appendix 6);
- an assessment of how successful their application might be in the future; and
- an identification of which causes of maternal mortality and morbidity appear amenable to a human rights approach.

The success of individual and collective efforts to apply human rights to prevent and remedy maternal mortality and morbidity will vary. However, each attempt to apply human rights generates further debate and understanding that is helpful to future efforts to foster compliance with requirements for safe motherhood.

1. Rights relating to life, survival and security

Notions of health are beginning to illuminate the content and meaning of the right to life and survival, the right to liberty and security of the person and the right to be free from inhuman and degrading treatment. This development is happening at both the national level, particularly in national courts, and at the regional and international levels. While these rights have yet to be applied to secure the services to promote safe motherhood, it is perhaps timely to think about how they can be applied for this purpose.

a. The right to life and survival

The Political Covenant, Article 6(1): "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

The right to life is the most obvious right that could be applied to protect a woman at risk of dying in childbirth due to lack of obstetric care. Historically, this right

generally has been applied legally only to ensure that capital punishment is not imposed in an arbitrary way. However, judicial tribunals are beginning to apply the right to life to matters relating to health by addressing the positive nature of the right, and by providing a context of health and human dignity to the right to life. For example, HRC has explained that "the expression 'inherent right to life' cannot be properly understood in a restrictive manner, and the protection of this right requires that States adopt positive measures."[92] When explaining what positive measures might be adopted, HRC gave, as an example, measures necessary to reduce infant mortality and to increase life expectancy.[93] HRC has specified through its General Comment on Equality between Men and Women that States Parties are now required to provide data on "pregnancy and childbirth-related deaths of women." (see Appendix 8, para 10)

In 1991, the European Commission of Human Rights considered a complaint alleging a state's violation of the right to life of a woman who had died in childbirth.[94] The Commission held that the complaint was inadmissible on technical grounds. However, the Commission took the opportunity to emphasize that the right to life in the European Convention[95] has to be interpreted not only to require states to take steps to prevent intentional killing, but also to take measures necessary to protect life against unintentional loss. The European Commission had earlier considered a claim that a governmental vaccination programme that resulted in damage and death to babies was a violation of the right to life.[96] The Commission found that appropriate and adequate measures to protect life had been taken in this case. The Commission did explain, however, that had the state not shown that such measures had been taken, the state would have been found in breach of its duty under human rights law to safeguard life and health. This shows that states are bound to explain and justify their efforts to protect their citizens' lives and health.

Given the magnitude of an estimated 1,400 maternal deaths worldwide each day, it is remarkable that so few legal proceedings have made their way into national courts to require that governments take all appropriate measures to identify the causes of maternal mortality in their respective countries, and take precautionary measures necessary to prevent further maternal deaths. This is due in part to families and communities in which women have died of pregnancy-related causes not understanding how governmental neglect of the conditions in which women bear pregnancies and give birth violates their right to life. Effective protection of the right to life requires that positive measures be taken that are necessary to ensure "access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[97]

Positive measures might include progressive steps are taken to ensure an increasing rate of births are assisted by skilled attendants, as required by the Cairo and Beijing processes.[98] Where such measures are not taken, states need to be encouraged to take steps to ensure compliance with treaty obligations to protect and promote the right to life.

Some national courts are giving an expanded meaning to the right to life that could be applied to require ministries of health to address the causes of preventable maternal deaths. For example, the Supreme Court of India decided that the right to

life contained in the Indian Constitution[99] was breached when various government hospitals denied a complainant emergency treatment for serious head injuries.[100] The Court explained that the state cannot use financial constraints to ignore its constitutional obligation to provide adequate medical services to preserve human life, and even detailed which measures the state might take to comply. While this case addressed emergency medical care to treat head injuries, the reasoning could be applied to require governments to provide emergency obstetric services where they are not sufficiently available.

The Venezuelan Supreme Court recognized the interrelationship between the rights to life[101] and to health[102] contained in the Venezuelan Constitution, when ruling in favour of a claim for HIV treatment.[103] In underscoring the positive nature of the right to life, the Court required the Ministry of Health to:

- provide the medicines prescribed by government doctors;
- cover the cost of HIV blood tests in order for patients to obtain the necessary anti-retroviral treatments and treatments for opportunistic infections;
- develop the policies and programmes necessary for affected patients' treatment and assistance; and
- make the reallocation of the budget necessary to carry out the decision of the Court.

While the successful claim was brought on behalf of 172 individuals living with HIV, the Court applied the decision to all people who are HIV positive in Venezuela.

As a result of these decisions, it is now timely to explore how a claim might be brought on behalf of women whose lives and health are at risk because of denial or neglect of life-saving obstetric care. Such a claim would certainly be feasible in Venezuela, and in light of the Supreme Court of India's judgement it might be credible in India and other countries, especially Commonwealth countries. Governmental health administrations might be wise to plan their resource allocations and programmes in anticipation of judicial sympathy with the courts in Venezuela and India, and of their need in court to explain the adequacy of their responses to the requirements of safe motherhood.

b. The right to liberty and security of the person

The Political Covenant, Article 9(1):

"Everyone has the right to liberty and security of the person ... No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law."

The right to liberty and security of the person is one of the strongest defences of individual integrity and the right of women to free choice of maternity. The right is being applied beyond its historical prohibition of arbitrary arrest or detention, to

require governments to provide health services when the lack of services jeopardises liberty and particularly health security of the person. The Inter-American Commission of Human Rights has recognized a right to the satisfaction of basic health needs as part of a right to personal security in observing that:

> "The essence of the legal obligation incurred by any government ... is to strive to attain the economic and social aspirations of its people by following an order that assigns priority to the basic needs of health, nutrition and education. The priority of the 'right to survival' and 'basic needs' is a natural consequence of the right to personal security."[104]

If governments and agencies to which they delegate responsibility to administer health services fail to provide conditions necessary for safe motherhood, they are accountable for violations of women's right to liberty and security of the person, and must take all appropriate steps to prevent and remedy the situation. Medical, social, health system and other factors that place a woman at risk of maternal mortality or morbidity deny her the right to security of her person. Health care agencies may have to take account of more than medical service remedies to address the causes of unsafe motherhood.

Unsafe abortion can be the second largest cause of maternal mortality in some countries, such as Colombia.[105] Where unsafe abortion is a major cause of maternal death, it may be possible to apply the right to liberty and security to require governments to improve services for treatment of unsafe abortion, to change restrictive laws regarding access to abortion and to ensure the provision of contraceptive and abortion services. The right to liberty and security has been applied by national constitutional courts in abortion cases to protect a woman's "freedom to decide if, when and how often" [106] to bear children. In Canada, for instance, the Supreme Court held that a restrictive criminal abortion provision violated a woman's right to security of the person.[107]

Several constitutional courts, including those of France,[108] Italy[109] and the Netherlands, [110] have found that liberal abortion laws are consistent with women's right to liberty. Even laws expressed only prohibitively usually have an implied exception that allows lawful abortion when a woman's life or enduring health is in danger. However, the punitive context of the law deters women from seeking medical treatment, and doctors from proposing it, where the public at large and medical practitioners in particular are not informed that restrictively worded laws have this exception for preservation of life and health.

Women's liberty and security require clinic policies and laws that ensure their care and confidentiality. Under the Women's Convention, CEDAW has made a General Recommendation reiterating the importance of confidentiality. The Recommendation observes that, although lack of confidentiality affects both men and women to a certain degree,

> "it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason [unreliable confidentiality], to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases

> where they have suffered sexual or physical violence." (see Appendix 4, para 12(d))

Given this clear explanation of the impact of failures to respect confidentiality, health care administrators and providers can appreciate that the absence of confidentiality is a contributing factor in maternal mortality and morbidity, and a violation of a woman's right to health and wider aspects of security.

The right to liberty and security of the person can be applied to require that positive measures be taken to ensure respect in the delivery of reproductive health services to women who are at particular risk. They include women, especially adolescent girls, presenting with stigmatizing conditions, such as unmarried or extra-marital pregnancy, or incomplete abortion. Sometimes, adolescents hesitate to seek reproductive health services because they fear that their confidentiality might be breached. They fear, perhaps incorrectly, that information about their sexual behaviour, which they have to make for appropriate health care, will be disclosed to their parents, parents of their partners, teachers and others. As a result, special care and attention needs to be given to informing adolescents in the community through positive assurances that confidentiality will be protected, and to training health personnel appropriately. Clinics may have to withhold information not only of what treatment their patients have received, but also of who their patients are, although some disclosure may be required for billing purposes.

c. The right to be free from inhuman and degrading treatment

The Political Covenant, Article 7: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment..."

Decisions of human rights tribunals have required states to ensure that health services are provided when their denial would constitute inhuman treatment. The European Court of Human Rights held that a governmental deportation of a person at an advanced stage of terminal AIDS to his own country, where he would have no hope of receiving appropriate care, would constitute inhuman treatment, contrary to Article 3 of the European Convention.[111] Similarly, denying a prison inmate any adequate medical treatment for his mental condition, even when he was liable to capital punishment, has been held to constitute inhuman treatment contrary to Article 7, and denial of respect for the inherent dignity of his person contrary to Article 10(1), of the Political Covenant.[112]

Accordingly, a state might be held bound to ensure provision of emergency obstetric care and treatment for maternal morbidities, because lack of such provision could constitute inhuman treatment and denial of respect for the inherent dignity of women. Care could provide for a woman's access to medically indicated treatment, which may include services to treat a high risk pregnancy, and to terminate pregnancy safely where her life or continuing health, including mental health and social well-being, are at risk.

HRC addressed the inhuman and degrading nature of maternal death from unskilled abortion in considering a report submitted by the Government of Peru under the Political Covenant. When examining what the country had done to bring its laws, policies and practices into compliance with the Covenant, the Committee addressed the human rights of women, including the rights denied them by Peru's restrictive criminal abortion law. In its Concluding Observations, the Committee expressed its concern "that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality."[113] The Committee found that the restrictions of the criminal law subjected women to inhuman treatment, contrary to Article 7 of the Covenant. Moreover, the Committee explained that this aspect of the criminal law was possibly incompatible with Article 3, on equal entitlement of men and women to enjoyment of the rights set forth in the Covenant. The Committee said this would include Article 6, which protects the right to life, since men could request medical care of a life endangering condition without fear that they or their care-providers would face criminal prosecution.

The Committee recommended that "necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the Covenant."[114] Moreover, the Committee explained that the "provisions of the Civil and Penal Codes [of Peru] should be revised in light of the obligations laid down in the Covenant," particularly Articles 3 and 26 requiring that countries ensure the rights of women under the Covenant.[115] The requirement that a country conform to human rights standards, if necessary by amending national law to be compatible with individuals' human rights entitlements, shows that governments can be expected to comply with the duties they have assumed to protect women's rights, including to safe motherhood.

A state is responsible, at a minimum, to require its health care providers and facilities to ensure women's reasonable access to safe abortion and related health services, as its law permits. Moreover, since the law in Peru, which strictly penalised abortion, was shown to result in inhuman treatment of women and undue maternal mortality, Peru was held obliged to consider legal reform so that its law would comply with human rights standards for women's health and dignity. A new national policy could be expressed in law that more adequately balances limitations on abortion with women's rights to safe and humane access to health services necessary to protect their lives and dignity, and their security in health.

2. Rights relating to maternity and health

a. Rights relating to maternity

Rights relating to maternity have been developed through interrelated rights requiring maternity protection in general, maternity protection during employment in particular, rights to marry and to found a family and, for instance, rights relating to free choice of maternity and to private and family life.

i. The right to maternity protection

The Economic Covenant, Article 10(2):

"Special protection should be accorded to mothers during a reasonable period before and after childbirth…"

The exact wording of Article 10(2) of the Economic Covenant, above, is found in Article 27(1) of the 1992 Constitution of Ghana. Other examples of national constitutional rights relating to family life that require the protection of motherhood include Article 10 of the 1980 Constitution of the Arab Republic of Egypt, which provides that "[t]he State shall guarantee the protection of motherhood…" Brazil's 1988 Constitution explains in Article 6 that protection of motherhood is a social right under the Constitution.

The special contribution that women make to society through maternity and motherhood is recognized in many national constitutions and human rights documents. Under Article 5(b) of the Women's Convention, States Parties agree to take all appropriate measures:

> "[t]o ensure that family education includes a proper understanding of maternity as a social function…"

The Universal Declaration of Human Rights in Article 25(2), addressing health and well-being, explains that

> "Motherhood and childhood are entitled to special care and assistance."

The American Declaration similarly recognizes that "[a]ll women, during pregnancy and the nursing period … have the right to special protection, care and aid."[116] Through Article 15 of the Protocol on Economic, Social and Cultural Rights to the American Convention, states agree to "provide special care and assistance to mothers during a reasonable period before and after childbirth."

Under Article 24(d) of the Children's Convention, States Parties commit to ensure appropriate prenatal and postnatal care for mothers. Article 12(2) of the Women's Convention requires provision of free maternity services where necessary:

> "… States Parties shall ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Where services that are appropriate for pregnancy, confinement and the postnatal period are not provided,[117] States Parties might be encouraged to take steps to provide these services in order that they are in compliance with Article 12(2) of the Women's Convention and Article 24(2) of the Children's Convention.

Necessary though these provisions are, their focus tends to link protection of women's health to motherhood and care of infants and children, reinforcing a perception that protection of women's health is an instrumental means of serving children, rather than an inherent right for women to enjoy for themselves. Whatever the motivation is for such provisions, they do obligate states to ensure that motherhood is safe. Legal research is needed to show if and how these provisions have been or could be applied to ensure women are adequately protected during pregnancy.

ii. The right to maternity protection during employment

Article 10(2) of the Economic Covenant requires that "working mothers should be accorded paid leave or leave with adequate social security benefits" during a reasonable period before and after childbirth. The maternal health of women during employment has been an objective of the International Labour Organisation (ILO) since its establishment in 1919. The Maternity Protection Convention, No. 3 (1919)[118] was among the first instruments to be adopted. The 1919 Convention stipulates in Article 3(c) that the pregnant woman is entitled to free attendance by a doctor or qualified midwife.

In 1952, this Convention was revised[119] to take into consideration developments in national law and practice. The 1952 Convention, Convention No. 103, began to reflect the increasing participation of women in the workforce, as well as rising social expectations regarding the rights of women during their childbearing years, particularly with respect to a growing commitment to eliminate discrimination in employment. The 1952 Convention provides in Article 4(1) for the material support of mother and child through financial benefits and medical care. Article 4(3) explains that medical care includes "prenatal, confinement and postnatal care by qualified midwives or medical practitioners as well as hospitalisation care where necessary; freedom of choice of doctor and freedom of choice between a public and private hospital" where applicable. The Maternity Protection Recommendation, No. 95 (1952),[120] provides further guidance on the health protection of employed women with regard to conditions of work, such as the prohibition of work prejudicial to the health of mother and child.

Article 1 of the 1952 Convention suggests that its provisions apply to "women employed in industrial undertakings and in non-industrial and agriculture occupations, including women wage earners working at home." However, the provisions of domestic laws defining the scope of persons to whom the maternity protections apply vary widely from country to country. Even so, a survey of legislation indicates that the scope of women whose maternity protection is covered in most countries approaches or exceeds that prescribed by the Convention, and is moving toward broad coverage for all employed women.[121] Women are generally covered across the industrial and non-industrial sectors, and in both the private and public sectors.[122] However, significant gaps still exist with respect to the agricultural sector, as well as to part-time workers, homeworkers, domestic workers, and casual, contract and temporary workers.[123] While these gaps are decreasing, much remains to be done to ensure that legal protection available in principle becomes effective in practice.

The 1952 Convention was further revised by the Maternity Protection Convention (Revised), 2000.[124] In addition, the 1952 Recommendation was revised in 2000.[125] These revisions were undertaken, in part, to reflect the growing commitment to eliminate discrimination in the workforce. Through all of these conventions and their accompanying recommendations, member states are obligated to devote attention to the health aspects of maternity protection, since they state that women have the right to medical care as well as to financial benefits.

iii. The right to marry and to found a family

The Political Covenant, Article 23:

"1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.
2. The right of men and women of marriageable age to marry and to found a family shall be recognized.
3. No marriage shall be entered into without the free and full consent of the intending spouses.
4. States Parties to the present Covenant shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution. In the case of dissolution, provision shall be made for the necessary protection of any children."

The obligations of states to protect the family are found in many human rights treaties (see Appendix 2). Wording similar to that of Article 23(1) of the Political Covenant is found in Article 18 of the African Charter requiring protection of the family. The exact wording of Article 23(1) is repeated in Article 17(1) of the American Convention. Article 23(2) is slightly revised in Article 17(2) of the American Convention, to read:

> "[t]he right of men and women of marriageable age to marry and to raise a family shall be recognized…"

Article 10(1) of the Economic Covenant stresses the importance of states ensuring protection and assistance for the "establishment" of the family and for "the care and education of dependent children." It reads:

> "The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses."

The Women's Convention stresses the importance of equal rights within the family. Article 16 reads:

> "(1) States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family

> relations and in particular shall ensure, on a basis of equality of men and women:
>
> (a) The same right to enter into marriage;
> (b) The same right to choose a spouse and to enter into marriage only with their free and full consent;
> (c) The same rights and responsibilities during marriage and at its dissolution…"
>
> (2) The betrothal and marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory."

Laws setting a legal minimum age of marriage, if implemented, can help to ensure that young women are of sufficient age and maturity to be able voluntarily to consent to marriage, and to avoid the health risks of premature childbearing.

Evidence shows while most countries have set a legal minimum age of marriage, governments generally do not provide the resources or the leadership for their effective implementation, for instance through a requirement of marriage licensing dependent on submission of evidence of age, such as dated certificates of birth. This is the case in India where marriage registration is not legally required. In their Concluding Observations on the report of India submitted under the Political Covenant, the HRC explained that:

> "[w]hile acknowledging measures taken to outlaw child marriages (Child Marriage Restraint Act) [which sets the minimum age of marriage at 18 for girls and 21 for boys], … the Committee remains gravely concerned that legislative measures are not sufficient and that measures designed to change the attitudes which allow such practices [child marriages] should be taken… The Committee therefore recommends that the Government take further measures to overcome these problems…."[126]

The Committee's concern about child marriages entered "without free and full consent of the intending spouses" is underscored by a study in Rajasthan, India which explained that:

> "[e]ven today, mass child marriage ceremonies arranged by parents, where hundred of boys and girls wed each other, are very common. The mean age at marriage for women (16.1 years) is among the lowest in the country. Once the girl goes to her marital home, it is her duty to beget a child as soon as she can. … Forcing early pregnancies and motherhood on teenage girls under the banner of social custom and family is tragic."[127]

The tragedy of child marriages is not unique to Rajasthan. CEDAW expressed similar concerns in its Concluding Observations on the report of Nepal in noting that:

> "traditional customs and practices detrimental to women and girls, such as child marriage, dowry, polygamy, deuki (a tradition of dedicating girls to a god or goddess, who become "temple prostitutes", which persists, despite the prohibition of the practice by the Children's Act), badi (the ethnic practice of forcing young girls to become prostitutes) and discriminatory practices that derive from the caste system are still prevalent."[128]

"Protection by society and the State"

There is significant scope for the right to marry and to found a family to be applied to advance safe motherhood, because this right imposes positive obligations on the state to protect the right. State authorities can be liable for not providing vulnerable women and girls with effective protection against the acts of private individuals. Courts of law are, of course, public authorities, and obliged to apply and develop the law consistently with human rights treaties binding their states. As a result, where governmental or judicial branches of the state do not constrain those who arrange marriages of children under the legal age of marriage, or against the will of one of the parties to the marriage, the government would be accountable for the state's violation of Article 23(1) of the Political Covenant.

The human right to family life is seriously jeopardised by neglect of the needs of women who are at risk of maternal death or disability to receive reproductive, including maternity, care. In addition, the rights to family life of children and fathers are prejudiced due to the harmful impact of mothers' deaths on the potential of surviving infants, children and other family members to lead healthy lives. Children of women who die following childbirth are "three to ten times more likely to die within two years than those with both living parents."[129] Preservation of maternal health and prevention of maternal death are so central to the enjoyment of family life that they are part of the human rights entitlements not only of women but also of children and husbands.

"Marriageable age"

The right to marry and to found a family, available to persons of "marriageable age," may be applied to achieve the desirable result of adolescent girls marrying later, giving them more choice over the age at which they have children. The expression "marriageable age" in Article 23(2) of the Political Covenant needs to be interpreted in light of the Children's Convention. Article 1 of that Convention explains that "a child means every human being below the age of eighteen unless, under the law applicable to the child, majority is attained earlier."

National family laws have traditionally set ages at which adolescents could marry without parental consent, and even over parental objection. This age often coincided with the general age of majority (traditionally 21 but now commonly 18). A lower age was also set at which adolescents could marry provided that their parents consented, or "emancipated" them. In addition, laws often had an exception allowing an underage girl to marry if she was pregnant, in order that her child would be legitimate at birth.

An objection to parental consent laws is that they protect marriages the parents arrange. Daughters may accept the arrangements as an act of obedience to their parents rather than of emotional commitment to their husbands and to raising their own children. Accordingly, the better view may be that the reference in legal provisions to "marriageable age" not be taken to refer to the minimum age of marriage with parental consent, but to the age of marriageability without the legal requirement of emancipation by parents.

This view is reinforced by the health advantages, for both mothers and children, of marriages not being undertaken before adolescent girls have achieved sufficient physical maturity to bear pregnancy and deliver safely, and the emotional and intellectual maturity for self-care, child-care, and resort to necessary assistance. Physical maturity can be approximately related to a chronological age, but this age may not be as reliably related to emotional and intellectual maturity.

Health and social effects of child marriage

HRC and other treaty monitoring bodies could benefit significantly from the work of women's health specialists in adding content and meaning to an understanding of "marriageable age." For example, a serious health dysfunction of early marriage and childbearing is younger girls' vulnerability to suffer different forms of obstetric fistulae. A fistula is a maternal disability arising from obstructed labour that has been reported particularly in Africa and Asia.[130] It has been explained that:

> "an obstetric fistula is a hole which forms in the vaginal wall communicating into the bladder (vesico-vaginal fistula – VVF) or the rectum (recto-vaginal fistula – RVF) or both (recto-vesico-vaginal fistula RVVF), as a result of prolonged and obstructed labour…The immediate consequences of such damage are urinary incontinence, faecal incontinence if the rectum is affected, and excoriation of the vulva from the constantly leaking urine and faeces. Secondary amenorrhoea is a frequently associated problem. Women who have survived prolonged obstructed labour may also suffer from local nerve damage which results in difficulty in walking, including foot drop."[131]

The social stigma resulting from obstetric fistulae can be devastating to those who cannot obtain prompt surgical repair. It has been explained that:

> "The social consequences of these physical disabilities are severe. Most victims of obstructed labour in which the fistula subsequently occurred will also have given birth to a stillborn baby. In some areas, a high percentage of fistulae occur during the first pregnancy. Women who live in cultures where childlessness is unacceptable will therefore suffer from this fact alone. As long as they are incontinent of urine they are also likely to be abandoned by their husbands on whom they are financially dependent, and will probably be ostracised by society."[132]

Moreover, in many situations the "social isolation compounds the woman's own belief that she is a disgrace and has brought shame on her family. Women with VVF often work alone, eat alone, use their own plates and utensils to eat and are not

allowed to cook for anyone else. In some cases they must live on the streets and beg."[133]

The denial of the right to enjoy marriage and to found a family that failure to prevent and remedy this condition causes is obvious from the history of women who suffer it. States need to ensure that adolescent girls are of sufficient physical maturity for marriage and childbearing. Once adolescent girls are married, states need to ensure that they obtain the necessary health care to survive pregnancy and delivery. In the event of complications, such as obstetric fistulae, states are obliged to ensure that they quickly obtain necessary surgical treatment in order that they may found and enjoy their families.

"Free and full consent"

The burden falls on those employing state authority, whether by enacting legislation or by taking executive or judicial action, to ensure that entry into marriage relationships conforms to human rights standards concerning women's voluntary choice to marry and protection of their health and welfare.

CESCR, in its Concluding Observations on the report from Suriname, recommended that "the laws permitting persons to marry without the acknowledgement or consent of the partner be abolished…"[134] In its Concluding Observations on the report of Cameroon, CESCR also deplored "the lack of progress made by the Government in combating … the forced early marriage of girls…."[135]

Significantly, the National Court of Justice of Papua New Guinea decided in favour of a girl who wanted to continue her education and find a job, over her family's opposition, instead of being married involuntarily.[136] In so doing, the Court declared unconstitutional the 'head pay' custom of providing young women for marriage or other employment in victims' families as part of legitimate compensation for causing accidental deaths.

The Court's judgement is consistent with CEDAW's General Recommendation on Equality in Marriage and Family Relations.[137] This Recommendation makes the following observation on Article 16(1)(a) and (b) of the Women's Convention:

> "A woman's right to choose a spouse and enter freely into marriage is central to her life and to her dignity and equality as a human being. An examination of States parties' reports discloses that there are countries which, on the basis of custom, religious beliefs or the ethnic origins of particular groups of people, permit forced marriages or remarriages. Other countries allow a woman's marriage to be arranged for payment or preferment and in others women's poverty forces them to marry foreign nationals for financial security. Subject to reasonable restrictions based for example on a woman's youth or consanguinity with her partner, a woman's right to choose when, if, and whom she will marry must be protected and enforced at law."[138]

This Recommendation has been echoed in HRC's General Comment 28 Equality of Rights between Men and Women, which explains that:

> "States are required to treat men and women equally in regard to marriage in accordance with article 23…. Men and women have the right to enter into marriage only with their free and full consent, and States have an obligation to protect the enjoyment of this right on an equal basis. Many factors may prevent women from being able to make the decision to marry freely. One factor relates to the minimum age for marriage. That age should be set by the State on the basis of equal criteria for men and women. These criteria should ensure women's capacity to make an informed and uncoerced decision. A second factor in some States may be that either by statutory or customary law a guardian, who is generally male, consents to the marriage instead of the woman herself, thereby preventing women from exercising a free choice." (see Appendix 8, para 23)

iv. The right to free choice of maternity/the right to private and family life

The Women's Convention, Article 16(1):

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure…

> (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

The Political Covenant, Article 17(1):

"No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence…."

The right to free choice of maternity is derived from the right to private and family life and the right to decide on the number and spacing of one's children. These rights, however formulated, are found in many national constitutions and human rights treaties. For example, the 1998 Constitution of Ecuador says that:

> "[t]he State shall guarantee the right of persons to decide on the number of children they want to conceive, adopt, maintain and educate. It is the obligation of the State to inform, educate and provide means that contribute to the exercise of this right."[139]

The implementation of such rights reduces state power to compel individuals to account to governmental officers for their reproductive choices, and to compel individuals to employ their reproductive capacities in compliance with governmental preferences. Free choice of maternity is increasingly recognized as an attribute of private and family life, in order that individuals may propose whether, when and how often to have children, without governmental control, accountability or coercion. The common approach now is that choices on reproductive practice and

health, including maternity, are private decisions between consenting partners, not governmental decisions. Accordingly, women may in principle protect their health in maternity by determining whether and when to plan pregnancy.

The issue of choice of termination of unplanned or health-endangering pregnancy remains legally contentious in many countries, although countries are progressively liberalising their laws.[140] Governmental agents such as police officers have powers of enquiry and investigation where criminal abortion is suspected that may prevail over human rights of privacy. Women are often deterred from seeking health care when they know that governmental officers could have access to their health care information. The deterrent effect on women is especially strong when others' knowledge of their pregnancy, or possible pregnancy, risks their exposure to disadvantage. They may fear, for instance, loss of personal and family reputation where pregnancy outside marriage is stigmatized, and subjection to personal violence, which in some cultures, notwithstanding prohibitive law, may go so far as to accommodate or only lightly punish a so-called "honour killing." Further, a premature end to a pregnancy of which those bound or disposed to notify police officers are aware may expose a woman, and perhaps others close to her, to investigation on suspicion of unlawfully inducing abortion.

Courts respecting women's choices on pregnancy and childbirth have relied on rights to private life to prevent potential fathers, whether married or unmarried, from forcing women to bear children against their will. The European Commission has held that a husband could not veto his wife's lawful abortion and force her to endure pregnancy against her will.[141] This decision gives priority to a wife's right of decision with respect to childbearing over a husband's right to family life in the birth of his child. Husbands' rights do not include the right even to be consulted about abortion, because wives' rights of confidentiality and privacy prevail. This reasoning supports the argument that the state has no greater interest in the birth of a child than a husband or biological father. As a result, the state should have no right to prevent women's choice about the timing of their families and their full exercise of their right to private and family life.[142]

A 1998 study of maternal mortality in Nepal indicates how the right of women to privacy is not sufficiently protected by prevailing practices regarding decisions to seek health care. The Nepalese study demonstrates that the husband is the most frequent decision-maker in whether to seek hospital maternity care,[143] and that delay in seeking care is a contributing factor to maternal deaths. The husband alone made the decision to seek care in 42.5% of all families that sought hospital care, and the husband and family of the husband together made the decision in 39.1% of the cases. In only 11.5% of cases did maternal family members make the decision. The Nepalese experience suggests that a great deal of effort is needed to educate husbands and wives and their families on the importance of seeking maternity care promptly, and the importance of respecting the woman's decision to seek care promptly when she feels in need of assistance.

b. The right to the highest attainable standard of health

The Economic Covenant, Article 12:

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The right to health is also protected by other regional and international human rights instruments (see Appendix 2) as well as by various national constitutions. The Constitution of the Federative Republic of Brazil is particularly clear in providing that:

> Health is the right of all and the duty of the State and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by the universal and equal access to all activities and services for its promotion, protection and recovery.[144]

The CESCR General Comment on Health significantly develops the understanding of what is required to implement the right (see Appendix 7). The General Comment explains that

> "the right to health in all its forms and at all levels contains the following interrelated and essential features:
>
> *(a) Availability* - functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary according to numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.
>
> *(b) Accessibility* - health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
>
> Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the

> population, in law and fact, without discrimination on any of the prohibited grounds.
>
> Physical accessibility: health facilities, goods and services must be within safe physical reach for all parts of the population, especially for vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitary facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
>
> Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, have to be based on the principle of equity ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
>
> Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
>
> *(c) Acceptability* - All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
>
> *(d) Quality* - As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation." (see Appendix 7, para 12)

WHO is currently working to develop indicators to determine how fully the substantive elements of the right to health services, namely their availability, accessibility, acceptability and quality, are satisfied. Laws and policies that unreasonably restrict health services according to these criteria would not comply with this right. For instance, a law or policy requiring unnecessary qualifications for health service providers will limit the availability of a service that contributes to safe motherhood. Examples of such policies are those that require excessive qualifications for health service providers to perform caesarean deliveries, and that require several specialists to determine satisfaction of criteria for lawful termination of pregnancy. Such policies may be proposed in good faith in order to ensure excellence in women's health care. However, it is poor policy, and may be a human

rights violation where health services are jeopardised, to allow the excellent to be the enemy of the good, or the good the enemy of the adequate.

Some or all of the standards proposed in the CESCR's General Comment on Health and other general recommendations, such as the CEDAW General Recommendation on Women and Health, and those arising out of the Cairo Programme and the Beijing Platform are used to determine whether states are in compliance or in violation with treaty obligations.[145] These standards are also reflected in UN agency consensus documents on the major components of a woman's right to health. For example, a report on maternal health care explains that women-friendly health services should:

(i) be available, accessible, affordable and acceptable;
(ii) respect technical standards of care by providing a continuum of services in the context of integrated and strengthened systems;
(iii) be implemented by staff motivated and backed up by supervisory, team-based training, and incentive-linked evaluation of performance; and
(iv) empower users as individuals and as a group by respecting their rights to information, choice, and participation.[146]

Much work is still required to apply the right to health care effectively so as to ensure the availability, accessibility, acceptability and quality of maternity services in particular countries. However, treaty-monitoring bodies, through their Concluding Observations on country reports, have made some significant beginnings. For example, CESCR, in its Concluding Observation on a report by Gambia, explained that:

> "[r]egarding the right to health in Article 12 of the Covenant, the Committee expresses its deep concern over the extremely high maternal mortality rate of 1,050 per 100,000 live births. UNICEF identifies the main causes to be haemorrhage and infection related to the lack of access to [appropriate services] and poor services."[147]

Important studies have been undertaken to show how tribunals have addressed the general right to health in different countries, through Concluding Observations and through complaint procedures.[148] These kinds of analyses could similarly be undertaken regarding the right of women to maternity care in general and obstetric services in particular.

i. Available resources

Under the Economic Covenant, states are required to take immediate and progressive steps to achieve specific health standards. States are judged on the extent to which they are moving toward "the realization" of the right to the highest attainable standard of health. CEDAW's General Recommendation on Women and Health provides that: "the duty to fulfil rights places an obligation on States parties to take appropriate … budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care" (see Appendix 4, para 17).

The Constitutional Court of South Africa has addressed the issue of whether the government is required under the South African Constitution[149] to provide long term dialysis treatment for a claimant's chronic renal failure.[150] The Court found that the government is not so required, because the constitutional obligations regarding access to health care services, including reproductive health care, "are dependent upon the resources available for such purposes, and … the corresponding rights themselves are limited by reason of the lack of resources."[151] The Court stated, however, that emergency services cannot be denied in situations where a person "suffers a sudden catastrophe which calls for immediate medical attention."[152] Thus, it would seem that under the South African Constitution, and possibly under similar provisions of other national constitutions, women seeking emergency obstetric care have a right of reasonable access to treatment.

A state's willingness in principle to give effect to women's rights to health and safe motherhood may be deterred by the fear that full implementation will have indeterminate economic consequences for the national health budget. A finding in a World Bank study, however, has "estimated that providing a standard 'package' of maternal and new-born health services would cost approximately $3 [U.S.] per person per year in a developing country; maternal health services alone could cost as little as $2 per person."[153]

The same World Bank study has also found that family planning and maternal health services are the most cost-effective governmental health interventions, in terms of death and disability prevented.[154] When a mother dies, the economy loses her productive contribution to the work force, her community loses the domestic and wider caring services of a vital member, and her death puts others around her at risk and impaired capacity to function in social, employment and other roles. Studies have shown that when their mother dies, the surviving children are three to ten times more likely to die within two years than children that live with both of their parents.[155]

The study also explains that the savings resulting from investing in maternal health and reduction of maternal morbidity are significant.[156] The population will have fewer poor women, and the work force will be healthier and therefore capable of higher productivity. Reducing maternal mortality and morbidity reduces household poverty and benefits the health system. Moreover, preventative care may save money when there are fewer sick women. Practical and economically viable solutions to the problem of maternal death and sickness include the purchase of a community ambulance where resources exist for fuel and maintenance of an ambulance, or financial help is available to a community to cover emergency transport costs.

ii. Economic access

Some policy makers advocate that users of services should pay at least partial or token fees. Their reasons include needs to raise revenues to be available for health care, but also fears that irrational use may be made of publicly funded health services. Moreover, there is a perceived need to impress upon users of health services that their use of services has economic costs. Paying from their own pockets is believed to bring home this reality to them, and to cause them to question whether

their request for services is based on a real health need, or is rather a frivolous indulgence at others' expense that they will not allow at their own. There is a market-based perception that people exercise rationality in expenditure of their own resources that they do not exercise in expenditure of others' or of public resources, and that cost-effective utilization of resources can be achieved by imposition of user fees for services.

It is uncertain and problematic what effect the imposition of user fees would have on safe motherhood among poor people in developing countries, particularly whether such fees would deter or prevent poor women's resort to necessary maternity care. A study on safe motherhood funded by the U.K. Department for International Development and WHO reported in 1999 that "[t]he paucity of relevant global, let alone local, information on cost poses a challenge to maternal health planners and managers in developing countries, for in the development of health financing schemes, programme costs are critical."[157] Evidence following removal of user fees by the post-apartheid government elected in South Africa in 1994 "suggests that gains in maternal health care … have been relatively modest," and that more deliveries within health facilities and improvements in the quality of services are also required to reduce maternal and perinatal mortality.[158]

Contrasting evidence has come from other countries experimenting with general user fees, including Kenya. A review of safe motherhood there has observed that:

> "Cost is known to affect both uptake and delays in seeking care. The GOK [Government of Kenya] introduced cost-sharing in 1989 for specific services, but excluding promotive and preventive services, which includes antenatal care … Evidence from other developing countries indicates a direct decline in utilization of maternity services linked with the introduction of user fees, and this will need to be monitored in Kenya. Fees appear to vary from facility to facility, but generally women are charged in proportion to the service rendered. A caesarean section for example, is more expensive than a normal delivery. This appears logical in terms of the health service inputs but may also be an important deterrent for poor women seeking care."[159]

The inability of impoverished families to pay for the full range of safe motherhood services, including antenatal, delivery and postpartum care, available only by payment, appears evident. When medical services are themselves free of charge, however, poverty may remain an obstacle to safe motherhood. It has been observed that:

> "Even when formal fees are low or non-existent, there can be other costs that deter women from seeking care. These costs may include transport, accommodation, drugs, and supplies, as well as informal or under the table fees that may be imposed by health staff. When women lack control over resources and are dependent on others to provide funds, fees of any kind can be a serious obstacle to their use of services."[160]

Proposed options to overcome economic barriers to safe motherhood services include making medical services free of charge, having means-related sliding fees, insurance schemes based on community membership or, for instance, employment

and community trust fund or loan schemes, each with advantages and disadvantages concerning coverage and effectiveness.

In responding to the problem of economic barriers to services that promote safe motherhood, and to economic conditions that aggravate unsafe motherhood, governments are accountable under the Economic Covenant for denials of the right to the highest attainable standard of health that are due to individuals' poverty. Moreover, Article 12(2) of the Women's Convention, addressing maternity services, requires States Parties to grant "free services where necessary."[161] Accordingly, governments will have to explain the extent to which, in their countries, measures of what standards of health are attainable include issues of personal poverty and of national allocation of economic and other resources.

iii. Transparency and fairness in the allocation of resources

Women whose governments have failed to address their basic obstetric needs in the allocation of health resources in a fair and transparent way may be able to ground a complaint in the right to procedural fairness in administrative decision-making. Courts are slowly applying the right to procedural fairness to require that health benefits are allocated equitably, or at least are not denied in an unfair or arbitrary way.[162] For example, the European Court of Human Rights has found that a sickness allowance should not be arbitrarily withdrawn.[163] This decision could be applied to require the restoration of health services, including maternity services, where they have been withdrawn in an unfair and arbitrary way, and governmental explanation and justification of policies that disfavour safe motherhood services against other health expenditures or budgetary allocations. Further, since in the world's prevailing global economy few if any countries exercise full fiscal sovereignty, governments may be amenable to international persuasion and inducement to invest in such services compatibly with their human rights undertakings.

c. The right to the benefits of scientific progress

The Economic Covenant, Article 15(1)(b):

"The States Parties to the present Covenant recognize the right of everyone…[t]o enjoy the benefits of scientific progress and its applications."

Scientific progress can play a vital role in the reduction of maternal mortality and morbidity rates. One of the most fundamental methods of reducing risk in pregnancy is to afford women the ability to plan the number and timing of their pregnancies; this can most easily be accomplished through the use of birth control technologies. The right to receive the benefits of scientific progress includes a woman's entitlement to receive the advantages of better and more acceptable means of fertility control, including emergency contraception and non-surgical methods of early abortion.

The right to the benefits of scientific progress can also support the claim that governments should spend public funds on research designed to benefit the reduction of maternal mortality. The modern history of ethical regulation of research involving human subjects originated in the trial of physicians who conducted

inhumane experiments on vulnerable subjects, including inmates of concentration camps, to serve military and scientific interests in the Second World War. Their trial before the International War Crimes Tribunal in Nuremberg resulted in the 1947 Nuremberg Code, which invoked concepts of human rights to prohibit non-consensual medical experimentation. The subsequent decades saw reinforcement of protections against improper medical experimentation in a series of international human rights conventions. Under this inspiration, medical research recovered its moral standing, and its benefits came to be almost universally recognized. In the 1980s it began to be perceived, however, that women were not participating equitably in these benefits.

Human rights protections had been implemented by rigorously excluding women of reproductive age from research initiatives, in order to guard against injuring unborn children. Their exclusion was also economic, since it was costly to have sufficiently large-scale studies to achieve statistically valid data on women at every stage of their menstrual cycle. The effect, however, was that women's health was not seriously studied, except regarding fertility. The health-related factors that predisposed women to maternal mortality and morbidity, other than fertility itself and its control, were under-researched.

In the 1980s it came to be realized, however, that women had been denied their collective human right to benefits of progress in medical science. Reversing the Nuremberg-influenced perception that individuals would be protected by their exclusion from medical studies, women's groups showed that women's health protection depended on scientific research, and that exclusion of research on women's health from governmental funding constituted discrimination. Women allied themselves with AIDS activists to require the conduct of medical research, to address and remedy causes of mortality and morbidity of special concern to them. They pointed to states' legal commitments, made for instance under Article 15 of the Economic Covenant, to respect their rights "to enjoy the benefits of scientific progress and its applications."

Health care providers can accordingly rely on this right to argue for funding to achieve equity in the recruitment of members of both sexes into studies, and in the topics they choose to investigate. Similarly, research agencies, health research centres and, for instance, governmental health departments should remember human rights responsibilities to pursue the goal of safe motherhood through sponsorship and support of appropriate scientific studies. These should include not only biomedical studies, but also epidemiological or public health research, health systems research and social science research that could expose and remedy social causes of unsafe motherhood.

3. Rights to non-discrimination and due respect for difference

The Political Covenant, Article 2(1):

"Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without discrimination of any kind, such as race, colour, sex, language, religion, political or other opinion, natural or social origin, property, birth or other status."

This Article is reinforced by Article 26 of the Political Covenant, which requires that:

> "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

Article 26 requires states to act against discrimination in all fields of civil and political rights and also of economic, social and cultural rights, including health. States are also obligated to eliminate laws, policies and practices that discriminate on specified and unspecified ("other status") grounds. It is therefore necessary to examine the ways in which states ensure that they eliminate discrimination on grounds of race, colour, sex, national or social origin. These are not the only prohibited grounds of discrimination that are risk factors for unsafe motherhood. The phrase "other status" would include other prohibited grounds of discrimination, such as age, rural residence and poverty, which can affect women's ability to exercise their rights regarding safe motherhood.

While each of these forms of discrimination can be addressed separately, in practice they often overlap. For instance, sex discrimination is frequently aggravated by discrimination on grounds of marital status, race, age, rural residence and class, often leaving women of young age, of minority racial groups and of lower socio-economic status living in rural areas the most vulnerable to the risk of maternal death. Thus, a state's government is required to address the intersections of different forms of discrimination such as sex and race.

States are obligated to change laws that discriminate on their face, or in their effect. An example of a law that is discriminatory on its face is a law that requires women, but not men, to obtain the authorization of their spouse in order to access health services. States are also required to change laws that are equal on their face but disproportionately disadvantage one group. Such laws include those that require everyone to pay the same for health care, but that leave services unaffordable by people not in paid employment, such as single mothers who care for dependent children. Another example of a policy that is superficially neutral but has a disproportionately harmful impact on women's health interests is a law that denies adolescents reproductive health information and services without parental consent. Such a policy will leave girls, but not boys, at risk of pregnancy. Where laws or

policies, whether on their face or in their effect, treat men and women differently with respect to their health needs, states are being required to provide reasons, and often compelling justifications, for such treatment.

The general right to non-discrimination requires that we treat the same interests without discrimination, for example providing equal access of all races to health care. However, the right to non-discrimination also entails treating significantly different interests in ways that adequately respect those differences. The right to sexual non-discrimination requires that societies treat different biological interests, such as pregnancy and childbirth, in ways that reasonably accommodate those differences. National courts and international tribunals have been vigilant in applying the right to non-discrimination to require the treatment of the same interests without discrimination, but they have yet effectively to apply the right to non-discrimination to protect women's distinct interests in safe pregnancy and childbirth.

a. Sex and gender

Women's Convention, Article 1:

"… the term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

The Women's Convention emphasizes the need to confront the different causes of women's inequality by addressing "all forms" of discrimination that women suffer. Legal prohibitions cover discrimination on grounds both of sex, which is a biological characteristic, and of gender, which is a social, cultural and psychological construct that identifies particular acts or functions with one sex, such as religious leaders being male and nurses female. Article 1 of the Women's Convention is reinforced by Article 3 of the Political Covenant. Article 3 requires that:

> "The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant."

HRC's General Comment on Equality Rights Between Men and Women makes clear that Article 26 of the Political Covenant, on the rights to equality before the law and equal protection of the law, requires states to act against discrimination in all spheres of civil and political and of economic, social and cultural rights (see Appendix 8). States are, therefore, obligated to eliminate all forms of discrimination against women in respect to all rights, for example to life, family and private life, and the right to the highest attainable standard of health.

The devastating paradox of many societies' observance of human rights is that they discriminate against women where differences between the sexes should not matter, but ignore the distinction where it is critical. States often discriminate in women's

access to educational, political, spiritual, economic and other opportunities, where sexual difference in capacity for insight, acquisition of knowledge and creative initiative is inconsequential, while ignoring women's vital need for appropriate treatment in maternal health care. If political, professional, religious and other influential institutions could be inspired to put the effort into respecting women's distinctive needs for maternal health care that they have historically put into discriminating against women in areas where sexual differences should not matter, considerable advancement would be achieved towards safe motherhood.[164]

i. Sex and gender non-discrimination in the family

International tribunals have held governments accountable for unequal treatment of women in regard to their right to enjoy family life. HRC required a state to alter its laws that disadvantaged female citizens, in that their foreign husbands' residency and citizenship rights were subject to review while those of the foreign wives of husbands who were citizens were not, in order to ensure equality of women and men with respect to family life.[165] States have also been put on notice to change differential legal ages of marriage, in part because they stereotype women into childbearing and service roles and can disproportionately prejudice their health.[166] In its Concluding Observations on the report of Mexico, CRC expressed its concern that:

> "the minimum legal ages for marriage of boys (16) and girls (14) in most of the states of the State party are too low and that these ages are different for boys and girls**.** This situation is contrary to the principles and provisions of the Convention [on the Rights of the Child] and constitutes a form of gender-based discrimination which affects the enjoyment of all rights. The Committee recommends that the State party undertake legislative reform, both at the federal and state levels, to raise and equalise the minimum legal ages for marriage of boys and girls."[167]

CEDAW has addressed how patriarchy is embedded in many national laws. In its Concluding Observations on the report of Guatemala, CEDAW explained that:

> "… the legal provision according to which the husband remained the head of the family and a woman needed the husband's permission to take up outside activities was contrary to the provisions of the Convention and extended the patriarchal system."[168]

Several governments are placing promotion of gender equality in the mainstream of many of their activities and concerns. For example, Nepal has improved the living standards of women at the grass-roots level by facilitating their access to loans from Mother's Groups' bank accounts. Through training, women developed leadership and communication skills that enabled them to begin to make decisions among options in life for themselves. This was the first step in equipping them with the ability to decide freely and in an informed manner how many children to bear, and how closely spaced their pregnancies should be.[169]

ii. Sex and gender non-discrimination in health

Women's right to equal access to necessary health care, including maternity care, is recognized in Article 12 of the Women's Convention, by which states agree to:

1. … take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure … access to health care services, including those related to family planning.
2. … ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

The content and meaning of this Article has been elaborated in CEDAW's General Recommendation on Women and Health, which includes the observation that:

> "Studies such as those which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care." (see Appendix 4, para 17)

This General Recommendation specifies the information that CEDAW requires on such breaches and on steps taken to achieve remedies, emphasizing rights of access to confidential family planning services, and notes that:

> "In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality." (see Appendix 4, para 18)

The Recommendation requires that state reports "must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture" (see Appendix 4, para 9). It also calls on states to:

> "Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion." (see Appendix 4, para 31(c)

Ministries of Health concerned about ensuring compliance with the right to non-discrimination in access to health services will need to assess the different ways in which women's rights might be violated in the health care context. Governments have already been put on notice about their failure to reform laws and policies that discriminate against women, such as policies that require women requesting health services to obtain the authorization of their husbands. For example, the CEDAW Concluding Observation on the report of Indonesia explained that laws requiring a

married woman to secure her husband's authorization to obtain certain reproductive health services, even in emergency situations, are discriminatory and not in accordance with the Women's Convention.[170]

Treaty monitoring bodies have also signalled the importance of member states allocating resources fairly in ways that are appropriate to women's particular needs to go safely through pregnancy and childbirth. In its Concluding Observations on the report of Venezuela, for instance, CEDAW noted with concern:

> "the reduction of health budgets, the rise in the maternal mortality rate, the lack of and limited access to family-planning programmes (especially for teenagers), and women's limited access to public health services. In addition, legislation that criminalized abortion, even in cases of incest or rape, remains in force."[171]

CESCR, in its Concluding Observations on a report by Paraguay, expressed its concern about the inequitable distribution of health services between urban and rural areas, which resulted in higher rates of maternal mortality in the rural areas.[172] HRC has required a state to provide women with the same entitlements to social security benefits as men enjoy.[173] The same reasoning could be applied to require states to ensure equal access of men and women to health care appropriate to their needs.

b. Marital status

The Women's Convention requires that women exercise their rights "irrespective of their marital status." Articles 2 and 26 of the Political Covenant require the elimination of discrimination on grounds of marital status because they prohibit "discrimination of any kind, such as … sex … or other status." Nonetheless, discrimination on grounds of marital status pervades practices, social attitudes and laws of many countries, particularly in the area of family law, often called the law of personal status. The stigmatization experienced by women who are pregnant outside marriage, even when they become so through sexual assaults or abuse, may impair their access to care and the quality of the care they receive, aggravating their vulnerability to unsafe motherhood.

Many family and related laws were modelled on families founded according to conservative orthodoxies of legal marriage. Many countries retain legislated provisions, governmental practices and, for instance, judicial rulings that favour married couples over unmarried cohabiting and un-partnered individuals. Increasingly, however, human rights entitlements of unmarried unions and single mothers are gaining recognition. CEDAW has expressed its concern regarding, for instance, the Dominican Republic that "[d]iscriminatory provisions regarding unmarried women, as well as single mothers, persist in social security provisions and in land inheritance rights under the agrarian reform law…"[174]

c. Age

The Children's Convention, Article 2:

"1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment…"

Discrimination based on age is a common violation of women's reproductive rights.[175] Young women often suffer in communities that deny or impede the expression of natural adolescent sexuality. This fact takes on a heightened significance in light of the increased risk that premature pregnancy brings. It has been established that women who give birth before age 18 are three times more likely to die in childbirth than women over 18.[176]

While international law clearly protects children's rights to equal care with adults, young women's reproductive health services are often overlooked, and even opposed. The Children's Convention, which defines a child as a human being below the age of 18 years, provides in Article 24(1) that "[s]tates parties shall strive to ensure that no child is deprived of his or her right of access to … health care services." The interdependence of mother and child is recognized in Article 24(2)(d), by which states agree to take measures "[t]o ensure appropriate pre-natal and post-natal care for mothers." The full realization of these rights is vital for the reduction of maternal mortality and morbidity, as well as for children's survival and health.

Laws that detract from girls' equality with boys often impede adolescent girls' access to protective health services and erode their control over their reproductive lives. Intellectually mature young women's vulnerability to age and sex discrimination is deepened when reproductive health services are made available to them only on the condition of parental authorization, while it is available to adults without need for authorization. Mature adolescents suffer unjust discrimination when they are not free to obtain reproductive health counselling and services with the same confidentiality as adults. The Children's Convention requires that:

> "States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her rights *in a manner consistent with the evolving capacities of the child.*"[177] (emphasis added)

Courts tend to favour interpretation of laws on adolescents' legal powers by taking due account of "the evolving capacities of the child." Courts do not generally permit parents to veto their mature adolescent children's access to reproductive health services solely on grounds of minor age. Courts often determine that parental powers over their children are not absolute, but decrease as children's decision-making capacity advances, and parental choices can be overridden by the courts. A

common judicial approach is to recognize that parental rights exist not for the benefit of the parents, third parties or society, but for the benefit of the children. Laws equip parents to discharge their legal responsibilities to protect the best health and related interests of their children, but not to be arbitrary or to pursue their own convictions by risking their children's health or well-being.

Adolescents' disadvantages in resort to reproductive health counselling and services might be a reason why adolescents often report late for health services. Adolescents may fear that they will not be afforded the same confidentiality as adult women seeking the same services. Many health service providers will recognize minors' rights to health care and confidentiality if they demonstrate intellectual maturity or emancipation. However, clinic policies or laws that set chronological age limits for types of care, and deny reproductive health services to adolescent girls that they are capable to request according to their evolving capacities, violate the Children's Convention.[178]

Human rights monitoring bodies are beginning to expose violations of the rights of adolescent girls. For example, CRC expressed its concern "about the relatively high maternal mortality rate, especially as it affects young girls" in Nicaragua. It also noted that clandestine abortions and teenage pregnancies appear to be a serious problem in the country.[179] The Committee recommended that "the State party consider the possibility of focusing its attention on the organization of a more comprehensive and coordinated campaign in order to address the interrelated family and social-related problems of the high number of family separations, the relatively high maternal mortality rate and teenage pregnancies…"[180]

CEDAW has noted the importance of improving adolescent reproductive health. In its Concluding Observations on the report of Saint Vincent and the Grenadines, the Committee noted the "very high rate of pre-teen and teenage pregnancy" and recommended improved reproductive health services and information for this age group.[181] Safe motherhood advocates can build on this foundation to encourage governments to eliminate discriminatory laws and practices that disadvantage younger women, and cause them to experience unplanned pregnancy and unsafe motherhood.

When addressing maternal deaths of children and adolescents, investigators should examine the extent to which governments have implemented laws enacted to protect women's interests, such as laws that prohibit child marriages. The age of marriage will often dictate a woman's ability to retain choice over the timing of her pregnancies. Unenforced minimum marriage age laws and legal provisions and practices that condone child marriages discriminate against women on the basis of age.

d. Race and ethnicity

The Race Convention, Article 1:

"… the term 'racial discrimination' shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."

In many countries, health status among population groups varies by race and ethnicity, indicating differential access to health care services, information and education necessary for health protection. Statistics often show disparity in the risk of maternal death between majority and minority populations. In Australia, for instance, the aboriginal population is at up to ten times greater risk of maternal death than the non-aboriginal population.[182] Differences exist even where populations live in the same cities, such as in the United States, where the black population has a relative risk of maternal death 4.3 times higher than the non-black population.[183] A report on maternal deaths in Suriname also suggests a correlation between ethnic origin and rates of maternal mortality.[184]

Higher rates can result from the fact that ethnically marginalized groups have poorer socio-economic status than mainstream communities, and less access to necessary health care. Some groups have genetic traits that can cause more acute problems during pregnancy. For example, certain groups of black women and certain groups of women from the Mediterranean region who have sickle cell anaemia suffer related difficult and painful problems during pregnancy, labour and the postpartum period.[185] Sickle cell anaemia comes from a genetic trait that makes those with this condition more resistant to malaria, but also more disposed to maternal morbidity and mortality.

Regional and international human rights conventions' monitoring committees have called on states to comply with their immediate obligations to eliminate racial and ethnic discrimination that impedes access to health care generally, and to reproductive health care specifically. The Inter-American Commission has found Brazil to be in violation of its obligations under the American Declaration to take timely and effective measures to protect the health of the Yanomami Indians. [186] The Commission found breaches of the American Declaration provision that "every person has the right to preservation of his health through sanitary and social measures relating to … medical care, to the extent permitted by public and community resources."[187]

CERD has recommended in its Concluding Observations on the report from Cambodia that:

> "action be taken at the legislative, administrative and judicial levels to protect the right of everyone, including ethnic Vietnamese, to enjoy their rights under Article 5 of the Convention, especially the right … to public health and medical care…."[188]

CERD, in its General Recommendation on the definition of racial nondiscrimination, explained that it will consider any act to be discriminatory if it has an "unjustifiable disparate impact upon a group distinguished by race, colour, descent, or national or ethnic origin."[189] CEDAW asks States Parties to identify the "test by which they assess whether women have access to health care on a basis of equality between men and women in order to demonstrate compliance with Article 12" (emphasis in the original) (see Appendix 4, para 19). States are required to include comments on "the impact that health policies, procedures, laws and protocols have on women when compared to men."

In considering compounding forms of racial and gender discrimination, CERD has developed the General Recommendation on Gender Related Dimensions of Racial Discrimination. It explains that race discrimination can affect women in different ways, such as with regard to pregnancy, and to different degrees than men experience, such as regarding access to complaint procedures to remedy race discrimination (see Appendix 9). This General Recommendation explains that CERD intends to integrate a gender perspective in examining different forms of racial discrimination. It will do so by analysing

> "the relationship between gender and racial discrimination, by giving particular consideration to:
>
> a) the form and manifestation of racial discrimination;
> b) the circumstances in which racial discrimination occurs;
> c) the consequences of racial discrimination;
> d) the availability and accessibility of remedies and complaint mechanisms for racial discrimination." (see Appendix 9, para 5)

Racial discrimination against women of ethnic or racial groupings manifests itself because of their reproductive capacities. It has been reported that some indigenous women in Mexico do not seek delivery care from particular health clinics for fear of being sterilized during delivery.[190]

Strategies to ensure availability and accessibility of remedies need to be developed where the potential for abuse or neglect of rights relating to safe motherhood is high among particular racial or ethnic groups. Ministries of Health might consider appointing persons from vulnerable racial or ethnic communities as reproductive rights advocates or ombudsmen to monitor community members' access to reproductive health services, and guard against racial discrimination in access to safe motherhood services. Their attention need not be limited to pregnant women, but may extend to all members at risk of unsafe motherhood due, for instance, to inadequate means to achieve reproductive choice and birth spacing. At a governmental or public health level, similar steps might be taken to ensure non-discrimination on grounds of race or ethnicity in allocation of reproductive health resources among districts and regions of different racial composition.

4. Rights relating to information and education

a. The right to receive and to impart information

> The Political Covenant, Article 19:
> "…
> 2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.
> 3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
> (a) For the respect of the rights and reputations of others;
> (b) For the protection of national security or of public order (ordre public), or of public health or morals."

Traditionally, the right to information has been understood to guarantee freedom to seek, receive and impart information and ideas free from government interference. However, some commentators now argue that the right has evolved to the point where governments have concrete and immediate obligations to provide information that is necessary for the protection and promotion of reproductive health and choice, not just to refrain from interfering with its provision.[191]

The claim that governments have positive duties to ensure access to information that is necessary for individuals to protect their health is increasingly supported by decisions of human rights tribunals and international treaty provisions. The right to receive information might be shown to have been violated where a maternal death could have been avoided with appropriate dissemination of information regarding what constitutes a complication, means to prevent a complication, or where to receive care for such a complication.

The significance of access to information on reproductive health is underscored by the Women's Convention, which requires that women have access to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[192] Nonetheless, in a number of countries it remains a criminal offence, sometimes described as a crime against morality, to spread information not only of where women can get pregnancy termination services, but also of contraceptive methods.[193]

The European Court of Human Rights has examined whether a court injunction issued to prohibit the provision of information regarding availability of abortion services violated the right to freedom of expression.[194] The Court held that a governmental ban on counselling and circulation of information regarding where to find legal abortions in another country violated the right to impart and receive information.

The rights to information itself and regarding access to reproductive health services in particular are two of the most vital reproductive rights. To make informed choices about their reproductive lives, women need to be able to receive information on

family planning methods and services, and have access to methods and services they find preferable. The European Court has emphasized the connection between access to information and health risk, finding that an injunction preventing the provision of information on where to find abortion services

> "… created a risk to health of those women who are now seeking abortions at a later stage in their pregnancy, due to lack of proper counselling, and who are not availing of customary medical supervision after the abortion has taken place. Moreover, the injunction may have had more adverse effects on women who were not sufficiently resourceful or had not the necessary level of education to have access to alternative sources of information."[195]

It would seem, therefore, that human rights tribunals will be especially vigilant in reviewing cases alleging infringements on the right to information that is necessary to protect reproductive health, and where such infringements may disproportionately disadvantage those who lack resources or education. This decision could be applied to require governments to provide the information necessary to ensure that individuals can protect their maternal health.

b. The right to education

The Economic Covenant, Article 13:

"1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society…
2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:

(a) Primary education shall be compulsory and available to all;
(b) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;
(c) Higher education shall be made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular by the progressive introduction of free education;

…

3. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians, to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions."

There is a strong relation between girls' access to education and literacy, and reduced maternal mortality. Key factors in reducing maternal death in a number of countries, including Sri Lanka, Kerala State in India, Cuba and China have been the combined effects of education and empowerment strategies for girls, and improved

access to necessary health services.[196] National courts can contribute to these effects by applying the right to education to require that the state ensure the provision of free primary education.

The Supreme Court of India, for example, relying on Article 13 of the Economic Covenant, explained that the state is obligated to provide every child with free education until he or she completes the age of fourteen years.[197] The Court explained that the right to education is implicit in the right to life and personal liberty contained in Article 21 of the Indian Constitution, but is not an absolute right. After children reach the age of fourteen, their right to education is subject to the limits of economic capacity and development of the state. The Court emphasized that the Indian Constitution requires that "the State shall promote with special care the educational and economic interests of the weaker sections of the people … and shall protect them from social injustice and all forms of exploitation."[198]

National courts are also requiring that educational authorities ensure equal educational opportunities for girls. The highest court for England, the House of Lords, held that the Birmingham local education authority was treating girls less favourably than boys, contrary to the Sex Discrimination Act 1975, because there were fewer places for girls than boys in secondary schools.[199]

Where attempts to introduce compulsory sex education into schools are challenged, courts generally tend to favour such education. For example, the European Court of Human Rights addressed the human rights dimensions of a state requiring a sex education course in its schools. The European Court required sensitivity to parents' views, but upheld a compulsory sex education course in the state's schools because

> "the curriculum is conveyed in an objective, critical and pluralistic manner [and does not] pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions."[200]

The courts tend to favour access to educational opportunities, on a basis of equality of the sexes, because they recognize education as a foundation of individual autonomy and responsibility. Women able to exercise self-determination in their sexual relationships and responsibility in the choice, timing and spacing of pregnancies increase their likelihood to have safe maternity.

The significance of literacy and education to safe motherhood is evident in various ways. Information regarding the safest time and conditions for pregnancy, and particularly warning signs of unsafe motherhood, is frequently offered and reinforced in written pamphlets and texts. Warning notices of health hazards in general and hazards to pregnant women in particular have to be read and reread to be effective. Literacy aids but is not a precondition to development of a trained, critical and well-informed mind.

Education equips women to distinguish between customary practices that incorporate scientific understanding on what aids and impairs safe motherhood, and customs that misunderstand or incompletely understand cause-and-effect relationships. For instance in some parts of the world, as recently studied in Vietnam, women unknowingly compromise the safety of their pregnancies, for

themselves and the infants they deliver, because of prevailing myths to avoid obstructed labour. They believe that restricting their food, "eating down," will enable them to avoid obstructed labour by producing smaller babies.[201] However, low weight gain in pregnancy due to "eating down" aggravates maternal and infant mortality and morbidity. Women can be educated to understand how their health, dependent on adequate nutrition, aids survival and health of their children and themselves.

Moreover, when policy makers, healthcare workers and community and women's organizations are educated about the connection between lifetime nutrition of girls and women, various micronutrient deficiencies and maternal and neonatal health and survival, they can encourage policies that promote maternal nutrition and promote adequate weight gain during pregnancy.[202]

D. Performance Standards

Performance standards enable courts and treaty monitoring bodies to determine whether governments are meeting their obligations to respect, protect and fulfil rights relating to safe motherhood. Different standards exist that can be used to show whether governments are meeting their obligations with regard to a range of human rights related to safe motherhood. They include, but are not limited to:

- standards in national legislation and developed by national courts, for example that require access to certain kinds of care such as emergency care;[203]

- standards in international documents, such as those developed by the Cairo and Beijing processes, for example ensuring that at least 50% of all births should be assisted by skilled attendants by the year 2010;[204] and

- standards that have evolved through the treaty monitoring bodies, such as those requiring equality in access to health care.

Some treaty bodies, such as CEDAW, are using the agreed goals of the Cairo and Beijing processes as performance standards[205] to determine whether states are in compliance with or violation of their obligations under the Women's Convention.

UN agencies have developed indicators that are used to give a general overview of the reproductive health situation in particular settings. They include, but are not limited to:

- health status indicators, such as measures of maternal mortality and morbidity;

- health service indicators that show the availability and the accessibility of services, such as the percentage of births attended by skilled birth attendants; and

- health policy indicators, such as laws and policies favourable to adolescent health, or the degree of enforcement of a legal age of marriage.

Some of these indicators are more developed than other indicators, the health policy indicators being the least well developed. No single indicator can reflect the complete reproductive health status of a community. Indicators can be used in different ways in the human rights context. Where they show for instance that women in a country are in poor reproductive health, this may suggest that the government needs to do more to comply with its obligations to ensure the right to equality in access to health services.

Indicators can also be used to show trends over time. Where trends show improvement, this suggests that governments are progressing toward the realization of the right to the highest attainable standard of reproductive health. Where the trends do not show improvement or where they indicate continuing poor reproductive health, the data could then shift the burden to governments to explain the situation. If the indicators show default in satisfying performance standards, a government could be said to be infringing the right to the highest attainable standard of reproductive health, and will need to give greater priority to protection of this right.

1. Global indicators for monitoring reproductive health

It would be helpful to apply the WHO global indicators for monitoring reproductive health[206] to determine whether the standards on availability, accessibility, acceptability and quality of reproductive health services, established by CESCR's General Comment on the Right to Health (see Appendix 7, para 12), are being met.[207] These global indicators include:

- Contraceptive prevalence rate
- Maternal mortality ratio (see Appendix 1)
- Percentage of women who were attended, at least once during pregnancy, by skilled health personnel for reasons relating to pregnancy
- Percentage of births attended by skilled health personnel
- Number of facilities with functioning basic essential obstetric care per 500,000 population
- Number of facilities with functioning comprehensive essential obstetric care per 500, 000 population
- Percentage of live births of low birth weight (<2500g)
- Percentage of women of reproductive age (15-49) screened for haemoglobin levels who are anaemic
- Percentage of obstetric and gynaecology admissions owing to [unsafe] abortion
- Prevalence of fertility in women
- Positive syphilis serology prevalence in pregnant women.[208]

To illustrate how indicators would work in a human rights context, WHO estimates that only 55% of women in the developing world are attended at delivery by a health worker who has received at least the minimum of necessary training.[209] A skilled birth attendant can ensure hygiene during labour and delivery, provide safe and non-traumatic care, recognize and manage complications and, if needed, refer the mother to a higher level of care. The Cairo Plus Five document offers a standard by which

to measure the degree of compliance with the right to the highest attainable standard of health:

> "In order to monitor progress towards the achievement of the Conference's goals for maternal mortality, countries should use the proportion of births assisted by skilled attendants as a benchmark indicator. By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent, and by 2015, 90 per cent." [210]

WHO and other UN agencies and organizations maintain databases on the various global indicators for monitoring reproductive health. Efforts are under way to coordinate the different data bases. Data bases also exist for other indicators, such as perinatal mortality rates and a woman's lifetime risk of maternal mortality (see Appendix 1). These databases are very useful to treaty monitoring bodies, because they assist to determine whether a country is in compliance with or violation of the right to the highest attainable standard of health. Where indicators, based on country data, show that the country is meeting, for instance, the Cairo performance standard, then a human rights treaty monitoring body will assess that country to be in compliance.

Even where indicators are subject to some uncertainty, they can tell us something about the extent to which laws are actually implemented. For example, the percentage of adolescent girls who marry below the legal age of marriage, and data on age at first birth within marriage, can indicate the extent to which a government is vigilant in implementation of laws that could positively affect the outcomes of pregnancy and childbirth. Where the data show that many girls are marrying under the legal age of marriage, or delivering their first birth below the legal age of marriage, the data can be used to shift the burden to government to explain its actions and proposals to effectively implement the law. Where no satisfactory governmental explanation is forthcoming, the government needs to be encouraged to take appropriate steps to comply.

2. Guidelines for monitoring the availability and use of obstetric services

Guidelines have been developed by UNICEF and other UN partners for monitoring the availability and use of obstetric services by women with life-threatening complications.[211] Impressive work has suggested how these Guidelines can assist treaty monitoring bodies in considering whether states are providing maternal health services consistently with the right of women under Article 12 of the Economic Covenant to "the enjoyment of the highest attainable standard of physical and mental health." [212] The Guidelines propose six questions for monitoring the availability and use of obstetric services by women whose pregnancies present risks of life-threatening complications: [213]

1. Are there enough health facilities providing life-saving care for women with obstetric complications?

The Guidelines suggest that a global minimum level of availability of essential obstetric care (EOC) facilities is that, for every 500,000 persons in the population, there should be four Basic EOC facilities and one Comprehensive EOC facility. Many life-threatening complications can either be appropriately treated at a Basic EOC facility, or else the woman can be given enough treatment so that she will arrive at the Comprehensive facility in better condition for survival and recovery of her health.

2. Are these facilities equitably distributed across the population?

Information on the number of functioning EOC facilities distributed by geographic area will reveal regional discrepancies in the availability of life-saving obstetric services.

3. Are pregnant women using these facilities?

About 15 percent of pregnant women may develop serious complications and require essential obstetric care.[214] As a result, if 15 percent or fewer of pregnant women deliver in EOC facilities, it may be that some women with complications are delivering without the care they need.

4. Are pregnant women with obstetric complications using these facilities?

The indicator of the "met need" measures the extent to which women with needs for emergency obstetric care obtain it. Emergency obstetric complications include ante- or postpartum haemorrhage, prolonged or obstructed labour, sepsis, abortion complications, pre-eclampsia or eclampsia, ectopic pregnancy and ruptured uterus. This indicator measures the percentage of the estimated number of pregnant women with complications (15 percent of live births) who obtain treatment at a Basic or Comprehensive EOC facility.

5. Are these facilities providing enough life-saving surgery to meet the needs of the population?

Because surgical data are more often available than data on treatment of complications, the UN Guidelines include an indicator of unmet need for caesarean sections.[215] The UN Guidelines explain that the minimum need for caesarean section deliveries is usually taken to be 5 percent of births in the population, which is lower than in most developed countries, and, because of danger of overuse, a maximum acceptable level is taken to be 15 percent. If the rate of caesarean deliveries in a health facility falls below (or above) these levels, it indicates that inadequate (or excessive) services are being provided.

6. Is the quality of these services adequate?

Quality indicators are complex, and only a very crude indicator can be used to measure the proportion of women admitted to a facility with obstetric complications

who die (called the “case fatality rate”), because factors of age, health and reproductive history are significant. Overall, the maximum acceptable level is set at 1 percent. In other words, if given proper care, at least 99 percent of the women admitted for obstetric complications should survive.[216] A higher rate indicates cause for concern that services are of inadequate quality.

These six questions could be helpful for treaty monitoring bodies to ask in assessing reports from countries with high rates of maternal mortality. A negative or inadequate answer to any one of these questions suggests that a state is not complying with its positive obligations to provide maternity care, and would at least shift the burden to its government to explain the steps that it is taking to protect women during pregnancy. Where answers show serious lack of provision of basic and comprehensive obstetric services, treaty monitoring bodies might want to go beyond expressing their “concern” or “serious concern,” to show how and why states are violating women’s rights to health in general, and to obstetric services in particular.

IV. Strategies for Implementation

Three general strategies may be proposed to advance safe motherhood through human rights:

- education and training to reinforce safe motherhood as a human right;
- negotiation for improved maternal health services and for other enabling conditions for improvement in maternal health; and
- implementation of accountability for safe motherhood at national, regional and international levels.

A. Education and Training

Human rights are, or should be, the concern of everyone, and the safety of women and children before, during and following birth concern the most fundamental interests of all humane societies. Nevertheless, particular occupational groups and office holders bear predominant responsibilities to be alert to human rights violations that diminish or compromise the safety of motherhood among the populations they serve and lead. Members of such occupations and holders of such offices have powers, both individually and through the institutions in which they engage with their colleagues to invoke human rights principles to promote safe motherhood at every level.

Health service providers are most immediately confronted with many of the obstacles to safe motherhood, including women's lack of access to key services, and can direct governmental attention to inadequacies in provision of care. Health facility administrators similarly struggle to overcome the resource shortages and cultural practices that impair safe motherhood. Human rights education and training of clinicians and health service administrators equip them to advocate for the relief of unsafe motherhood in terms familiar to government officers and legislators, and to the lawyers who advise them on the principles to be observed by responsible governments and countries; that is, by governments acting under the constitutional and other laws of their countries, and by countries that claim to meet their obligations under international law.

Workers in non-governmental organizations and local community workers have important roles in monitoring governmental agencies' discharge of their duties to respect, protect and promote human rights relevant to safe motherhood. Their education and training in employing strategies to implement human rights reinforce health professional and governmental efforts towards the common goal of women's survival of motherhood in health and security, and the well-being of families.

The commitment to social well-being and justice that health professionals often show through their provision of services can be spread and deepened through their education of themselves and others. Health care providers are educators of their patients, students and communities not only in good health practice, but also in the values that promote health. The concepts and attitudes that advance safe motherhood and associated health interests can be communicated by reference to human rights, including and perhaps beginning with women's rights to free choice of maternity,

safe motherhood and good health for their children, themselves and their families. As health service providers advance their own understanding of human rights, they equip themselves to educate and train their fellow providers, patients and communities in the rights most relevant to health in general and safe motherhood in particular.

Education of students is, of course, the function of medical, nursing and associated health professions' schools, and affiliated teaching hospitals and other facilities. Collaboration with law schools' human rights and health law teachers and students can facilitate and intensify professional education and training in human rights regarding health, to mutual advantage. That is, instructors and students in medical, nursing and related schools can gain exposure to the concepts and language of human rights, and law schools' teachers and students can be exposed to the realities that make concrete the need for respect of human rights relating to health care. Together, their initiatives will advance the application of human rights to make rights effective in practice to protect and promote the free choice of maternity and safety in motherhood.

Collaboration can extend to healthcare professionals' continuing education programmes and programmes for specialist certification. Similarly, training of instructors can introduce the concepts and language of human rights to reinforce explanations of existing health care practices, and show how reforms would better protect patients' human rights to a health status consistent with safe motherhood. Joint educational projects among health care and law school instructors and students on human rights to safe motherhood would educate them to explain their principles and practices effectively across disciplinary boundaries, and pave the way to better communication with patients and health service administrators. Professionals equipped and accustomed to provide explanations not dependent on the scientific, professional and academic jargon of particular disciplines can educate patients to understand, protect and achieve recognition of their human rights, and to collaborate with service providers in the promotion of human rights. Individuals and communities may thereby be empowered better to comprehend their circumstances, and take initiatives for their improvement particularly, but not only, towards safe motherhood.

Health care officials may refer to human rights of sexual and racial non-discrimination in implementing and advocating for health sector reforms that give substance to the right to equality in access to health care, including health services necessary for safe motherhood. Initiatives may range from the financial management of short-term budgeting, through longer-term financial and personnel planning. These could transform ethical, constitutional and legal commitments to human rights into prevailing realities of everyday life, reflected in the justified expectation that women will survive pregnancy and that families will rear their children in good health.

B. Negotiation

Negotiating with governmental agencies for laws, practices, policies and budgets that implement human rights presents a promising alternative to traditional adversarial methods invoked for protection of rights, such as initiating legal

proceedings in accessible courts. Indeed, international human rights instruments and procedures encourage, where possible, peaceful and consensual settlement of disputes before parties resort to legal procedures. For instance, the Charter of the United Nations requires in Article 33(1) that "the parties to any dispute…shall, *first of all*, seek a solution by negotiation… or other peaceful means of their own choice" (emphasis added).

Furthermore, some of the regional and international human rights treaties have procedures to promote friendly settlement of conflicts. For example, the Inter-American Commission of Human Rights has a friendly settlement procedure whereby the Commission will place itself "at the disposal of any of the parties concerned with a view to reaching a friendly settlement of the matter" with respect to the human rights recognized in the American Convention.[217] In accordance with Article 45 of its Regulations,[218] the Commission encourages either party to initiate friendly settlement procedures to resolve potential conflicts. Procedures of this nature suggest a framework for negotiation, based on principles of co-operation and joint commitment to mutually beneficial resolutions, such as reduction of maternal mortality and morbidity.

Governments are ultimately responsible for shaping and implementing laws that affect women's health interests, and have general accountability for achieving improvements in maternal healthcare and safe motherhood. Because NGOs can serve as a link between governments and women, they have incentives to initiate negotiations for changes to women's health programmes. Similarly, medical associations and specialized societies, such as of obstetricians and gynaecologists, may also advance proposals for improvements. Negotiations may begin with local levels of government for a particular change in a community, such as upgrading health facilities to provide additional services necessary for preventing maternal deaths.[219] Ultimately, an NGO or professional association may aim to negotiate with higher levels of government for more widespread changes to health policy and for law reform.

The central challenge in negotiating for change with respect to maternal mortality, however, lies in a perceived disparity in bargaining power between the parties. Many NGOs may feel that they lack the standing or connections to initiate conversation with government, and health care professionals who are employed by or through government agencies may consider public confrontation inappropriate. However, shared interests lie latent in every negotiation. Making shared interests explicit and formulating them as shared goals will help the negotiation process become amicable.[220]

For instance, governments affirm their commitments to human rights principles and do not oppose safe motherhood. However, their leaders, who are often men, may consider high levels of maternal mortality and morbidity to be inherent in women's condition, find the subordination and powerlessness of women to be part of the natural order, and be unaware of women's experiences. Starting from the position that women's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather, injustices that societies are able and obligated to remedy, as shown by parties able to initiate negotiations with them, governments may begin to understand their responsibility. Moreover, research and

experience related to maternal health may be brought into the negotiations, to demonstrate that safe motherhood initiatives are sound investments, offering high social and economic returns at low cost.[221] This may be important particularly to countries that are concerned to become more progressive and economically efficient.

During negotiation, to advance its own interests a party must try to see the situation from the perspective of the other.[222] For instance, a government might be sensitive to a variety of influences, including for instance those of religious organizations. Such influence may result in the country maintaining restrictive abortion laws, for example, even in the face of evidence that such restrictive legislation is associated with higher rates of unsafe abortion and correspondingly high mortality. Appreciating the government's interest in pleasing its various constituents, and accepting that abortion may be too complex an issue to contend with initially, a negotiating party might try to negotiate for high-quality services for treating and managing the complications of abortion, and for education and services to reduce the incidence of unplanned pregnancies that are liable to result in abortions.

Techniques of negotiation, increasingly referred to as Alternative Dispute Resolution (ADR), have become progressively studied and refined in recent years, and four key principles of effective ADR have been identified. They are:

- Separate the people from the problem

  Negotiating parties may be unfamiliar with each other, and may perceive the other through inaccurate stereotypes that obstruct recognition of areas of common ground between them. Regarding safe motherhood in particular, neither party will knowingly support the goal of unsafe motherhood, and a party seeking improvement should not state or imply an accusation that the other party is badly motivated, or to blame for harms. The problem should be stated and addressed in objective, never personal, terms.

- Focus on interests, not positions

  A party should impute worthy and shared interests to the other, and not take a position against the other that it feels bound to defend and invites the other to oppose. Similarly, a party should not impute a position to the other that it proposes to undermine or disprove. Maximising shared interests, making them explicit, and identifying them at a level of abstraction that the other party is able to adopt provides a basis of mutual respect, trust and advance. Similarly, recognizing the other party's proper interests that diverge from one's own limits that party's need to be self-defensive or indirect. For instance, recognition of a government's scarcity of resources and of the pressures it has to accommodate allows attention to be directed to the reconciliation of divergent interests without the distraction of self-defensiveness.

- Develop options for mutual gain

  Negotiation implies some give-and-take or exchange of goals, in contrast to the winner/loser division of adversarial litigation, and the winner-take-all belligerency it generates. Promotion of safe motherhood equips governments

to claim not only to have observed their human rights obligations, but also to have improved the lives of the women, children and families that compose their populations. Accordingly, implementation of supportive strategies provides gains for all parties negotiating for this goal. Mutuality of gains depends on plurality of purposes, however, and adherents to fundamentalist religious or other positions who feel unable to compromise central principles may present a limit to negotiated settlement of disputes over removal of barriers to safe motherhood. Nevertheless, interests in mutual tolerance may permit protection of adherents to different convictions, such as through laws allowing conscientious objection to lawful practices and prohibiting discrimination against adherents to particular belief systems.

- Insist on use of objective criteria

  Assessments should avoid subjective "good" or "bad," "effective" or "ineffective," or "high" or "low" criteria, but deal in objectively measurable quantities. For instance, the percentage of births attended by skilled health personnel can be shown to have fallen or risen against a given volume over a given time. Standards of measurable medical performance and similar performance standards are valuable in allowing agreement on the direction of movement, even when explanations of how or why the movement occurred differ.

C. Accountability for Compliance at National, Regional and International Levels

1. Accountability for governmental compliance

Fostering governmental compliance with human rights obligations to advance safe motherhood can be approached through a variety of different procedures at national, regional and international levels. One approach is to develop a set of best practices for reducing preventable causes of maternal mortality, and to show how these practices are in compliance with human rights obligations found in national laws and regional and international human rights treaties (see Appendix 3).

Lawyers and tribunals tend to approach applications of human rights to achieve remedies or preventive outcomes in the context of particular complaints. They will therefore work with health care providers for the purposes of:

- identifying the injuries and their causes;
- reviewing documentation of alleged violations of rights;
- determining which rights might have been or will be violated;
- assessing what remedies might be effective to address the injuries and their causes;
- determining which agencies are bound by duties to provide such remedies; and

- identifying procedures at domestic, regional and international levels that are available to compel observance of duties to remedy, prevent and/or punish human rights violations.[223]

Items in this approach are elaborated by relevant research into healthcare resources, practices and standards.

a. Identifying the injuries and their causes

The identification of injuries and their causes can be by reference to various sources, including maternal death reviews, which are comprised of both maternal death audits (analysing events in health care) and maternal verbal autopsies (analysing events in the community), studies showing high case fatality rates in a community, and studies showing a high percentage of women marrying below the legal age of marriage. Different data sources will indicate various kinds of causes of maternal mortality and morbidity. If the prevailing cause is lack of obstetric care, for instance, then data showing medical causes of maternal death, such as haemorrhage, that could have been avoided by obstetric care, will be important in arguing for improved obstetric services. If the perceived cause is found in barriers to access to care, such as women's vulnerability within the family structure, then data on how improved education or, for instance, economic opportunities will empower women to overcome family disadvantage will be important in arguing for improved access to care.

b. Reviewing documentation of alleged violations

Review of documentation of health service failures that constitute alleged violations of human rights is a necessary step in the process of holding governments accountable for unsafe motherhood. Data may be events-based, meaning based on particular episodes or histories of individuals, or standards-based, meaning that they show that governmental performance meets or falls short of its duties.[224]

The capacity has been observed in human rights practice for "promoting change by reporting facts."[225] Proponents of safe motherhood need to build and maintain their reputations for rigour and balance in presenting facts, in order to afford their reports necessary reliability. Data showing, for instance, high rates of maternal mortality or high rates of unsafe abortion[226] can shift the burden to governments to explain why they are not providing necessary obstetric care or contraceptive services. Reports, including those developed by the United Nations and its specialized agencies,[227] and by NGOs,[228] may demonstrate how governmental actions and neglect violate rights relating to maternal survival. Events-based and standards-based data can be used in evaluating how effectively a right in question has been protected, and whether an alternative approach to protection would be more effective.[229]

Documented events-based data, when put together with other data, can show that human rights abuses represent repeated practices or policies rather than merely individual aberrations. Cases can demonstrate the absence of government efforts to eliminate and remedy abuses, and can be employed to analyse trends over time. Abuses of identifiable individuals presented before tribunals can direct attention beyond their facts to the underlying conditions of abuse. Individual testimony can be

more effective than explanations of the history and statistics of violations of rights relating to safe motherhood. Testimony presented at such meetings as the Women's Tribunal at the NGO Forum of the 1995 Beijing Women's Conference,[230] for instance, can generate names that will come to personify victimization by abuse of basic human rights.

Standards-based data are used in human rights monitoring, where governments' discharge of their obligations is the focus of analysis.[231] Standards-based data are most useful when they refer to the basis and authority of the defined standards that are proposed for application.[232] Examining documents of international authority, such as the Cairo and Beijing documents, and General Comments, General Recommendations and Concluding Observations of treaty monitoring bodies, will provide guidance on international standards by which the performance of government agencies will be measured in assessment of their meeting of their human rights obligations with respect to safe motherhood. Concluding Observations of treaty bodies on state reports might be particularly useful, because they usually note their concerns with lack of government compliance with obligations to implement particular treaty rights.

c. Determining the rights violated

Human rights have yet to be adequately applied to address problems of maternal health and survival. Rights are rarely expressed in language that is directly applicable to maternal health. The challenge is to achieve collaboration among colleagues who can bring their individual knowledge of medicine, local culture and practice, law, health sector functioning and governmental structure to the task. How human rights could be applied to advance safe motherhood can be approached by:

- examining how tribunals have addressed alleged violations of women's rights and rights of access to, and availability of, health care services (see Appendix 6); and
- determining how these decisions could be applied in the context of safe motherhood.

d. Assessing what remedies might be effective

Whether proposed remedies are likely to be effective depends on proper identification of causes of unsafe motherhood. Nevertheless, for political, procedural and/or other reasons, best remedies may not be possible to pursue. Root causes of maternal ill-health may be too complex or culturally ingrained to be changed by outcomes less than fundamental social reform that cannot be achieved in the short term. Therefore, within the limits of resources, personnel, time and other practical constraints, outcomes may have to be targeted and remedies pursued that are less than perfect, but that will achieve significant advance in maternal health, within a realistic timeframe.

e. Determining agencies bound to provide remedies

As above, approaches that can be pursued may be found by reference to governmental agencies or tribunals that can be obliged to address and remedy a

failure of maternal health. It is a matter of strategy, opportunity and circumstance whether it is preferable to determine a goal and then seek agencies through which to act to achieve that goal, or to identify accessible agencies that can be motivated into action, and to pursue the goals that resort to such agencies can achieve.

Governmental agencies may be bound by different obligations. Obligations may originate by force of law, established at domestic, regional or international levels. Obligations may also originate through pressure that may be brought to bear by legal action, political persuasive power wielded by political, religious and other institutions including news media, and at times the force of public opinion. The higher that remedies are pursued, however, through domestic, regional and international agencies, the weaker that compulsory powers are to enforce compliance. The bodies that monitor regional and international human rights conventions often depend on the power of moral persuasion or condemnation, political embarrassment and national pride to induce reform, because they have no police or comparable forces to compel respect for their judgements.

Governmental officers sensitive to their and their agencies' reputations for humane management of the health needs of populations they claim to serve, and proud to act fairly, may be persuaded by findings of judicial and other inquiries that the administrations in which they participate could do more to protect human rights to safe motherhood.

f. Identifying procedures at domestic, regional and international levels

Procedures available at the domestic, regional and international levels to urge observance of duties to remedy, prevent and/or punish violations of rights to safe motherhood may be undertaken by a spectrum of means, ranging from more consensual, nonconfrontational discussions and inquiries to sharply adversarial political and legal action. Deciding which means are used will be a matter of political and social judgement.

The least invasive, most collegial approaches are to enquire of agencies that control maternal health services or service funding levels if they are satisfied that the results of their practices meet human rights standards of protection of motherhood. They may be presented with data from other comparable agencies or countries on levels of performance that meet such standards, and asked if they are performing at this level or have programmes in place to do so. If public data exist indicating that they are not meeting such standards, they can be asked how they propose to raise their performance to these standards of achievement. This approach supposes that questioners and agencies share common purposes, and questioners may offer assistance or advice on developments towards satisfaction of standards.

Responsible agencies may claim that their performance is satisfactory, or that they have no obligation, or means, to satisfy higher standards than they claim to be achieving. A response may be to call for an enquiry into the prevailing standards of agency performance, methods of determining the level and adequacy of standards agencies meet and intend to meet, and the source and extent of the obligations they are required to discharge. The conduct of such inquiries may be inquisitorial, in which an appointed investigator asks questions and seeks evidence, or it may be

adversarial, in which opposing interests present their evidence and question the evidence presented by others.

2. National approaches

In many parts of the world, experience is growing on the protection and promotion of human rights through a variety of national legal, quasi-legal, and customary law systems.[233] The way in which human rights are protected varies depending on national circumstances and priorities. Development of a national strategy for the protection of rights to safe motherhood will employ various means.

a. Ombudsmen

In some countries, officers already exist who are equipped to conduct their own inquiries, and perhaps receive representations on behalf of agencies and interests in dispute about facts, and about standards of safe motherhood that should be met. The model of the ombudsman is increasingly adopted. Through this model, institutions such as hospitals, government departments and private organizations appoint independent officers to conduct inquiries into their procedures at the request of patients, service recipients or, for instance, staff members.[234] Ombudsmen usually act by predetermined procedures to hear questions or complaints, to determine facts by their own inquiries and receipt of evidence from interested parties, and to present their conclusions. They may often make recommendations for reform, and for correction of improprieties that investigations have disclosed. For example, the Women's Ombud in Costa Rica has reported significant lapses in gynaecological and obstetric care, including lack of attention to privacy.[235]

b. Alternative dispute resolution

The model of the ombudsman presents a systematic example of alternative dispute resolution (ADR), (addressed in section IV.B. above) through an officer established in advance of any particular dispute. Commonly, however, disputes arise before systems for resolution are in place. ADR may be approached through agreement among parties in dispute to appoint a particular person to proceed in an agreed way, for instance with power to propose means by which the dispute can be resolved to parties' mutual satisfaction. ADR cannot work, however, when an agency complained against refuses to recognize the capacity of the complainant to question its performance. ADR is consensual, depending upon mutual recognition, respect and collaboration among parties.

c. Professional associations and licensing authorities

Where it is claimed that those bound by professional codes of ethics or conduct need to do more to comply with these codes, professional licensing or voluntary professional associations may be asked to conduct inquiries into professional conduct. Licensing authorities appointed by law, whose mandate is usually to protect the public against unqualified health care practice and unethical practice by those who are qualified, usually have power to compel licensed practitioners' attendance before disciplinary tribunals. Voluntary professional associations, such as national, regional or local medical and nursing associations, may also be entitled, under terms

of members' contracts of membership, to ensure that members observe conditions of membership, particularly that they act in accordance with associations' ethical requirements.

d. National human rights commissions

National human rights commissions, such as those in India, the Philippines, and Sri Lanka, and regional human rights commissions, or commissions more narrowly concerned with patients' or women's rights, provide other opportunities for investigation of complaints that might be used to promote human rights to safe motherhood. Some of these commissions are beginning to focus on the protection of economic, social and cultural rights, [236] and may provide forums to explore how these rights can be more effectively applied to advance safe motherhood.

e. Courts of law

As a measure of last resort, when consensual approaches have failed or been prevented, courts of law may be mobilized to conduct hearings according to civil law, administrative law or criminal law processes. Courts of law can compel participation of agencies that will not agree to informal resolution of disputes, such as by ADR. In some countries, separate constitutional courts exist, and can determine claims regarding human rights contained in constitutional documents. All courts of law conduct proceedings according to publicly available rules of practice, and are usually open to the public and reportable in news media. According to their traditions, they may conduct their hearings by adversarial or inquisitorial procedures, but will usually accommodate the arguments and evidence of parties to which they award standing to be heard. It is usually expected that they give reasons for their decisions, and that their decisions are issued publicly, and are enforceable by the authority of the state or of the tribunals themselves.

The status of international law and ratified conventions will be different in the courts of law of each country. Some require their legislatures specifically to enact legislation implementing a treaty into national law before it is applicable domestically. In others, such as Colombia, the constitution gives priority over national law to an international treaty that the country has ratified.[237]

The transcending problem of reliance on courts of law is that the justice they offer is frequently practically inaccessible to many people and interests. Access depends on the purchase of expensive legal skills, knowledge of detailed procedures, drafting and interpretation of complex legal documents, and willingness to be patient for many months or years for completion of sequential procedural steps leading to a final judgement. Trial judgements are often open to appeal, which prolongs the process to resolution, and increases complexities and costs. Governmental agencies have more resources, and often more influence and credibility, than private individuals and NGOs that take legal proceedings against them.

3. Regional and international approaches

To foster compliance with requirements of international treaties among members of the treaty regimes, their provisions usually include procedures for members

periodically to report on their compliance, for filing of complaints and for the appropriate conduct of inquiries. A careful reading of each convention is required to determine which procedures are available to achieve compliance, and the conditions to apply such procedures. An understanding of how rights have been applied within different regional[238] and international[239] treaty regimes is helpful.

a. Reporting procedures

Monitoring procedures exist under many regional and international human rights treaties that can be used to establish a member state's degree of compliance with rights relating to maternal death and disability. At a regional level, for example, the Inter-American Commission of Human Rights publishes annual reports that describe thematic problems, individual cases heard and the current assessment of human rights in the countries of the region. States Parties to international human rights conventions are obligated to report periodically on their national performance to the respective treaty monitoring body.[240]

State reports are generally structured around the separate articles of human rights treaties. Since the causes of maternal mortality are varied and often complex, efforts should be made to address individual causes under each of the relevant articles of treaties. States' previous reports and the Concluding Observations of the monitoring committees on those reports are helpful guides for drafting future reports.

Treaty monitoring committees welcome information that comes from UN agencies, and from "alternative" or "shadow" reports or comments on state performance submitted by NGOs.[241] Indeed, these treaty bodies can be more effective in monitoring compliance with rights relating to safe motherhood if they are supplied with authoritative information on the maternal health of women in reporting countries. Shadow reports may incorporate significant findings of states' abilities and performance in protecting and promoting maternal health,[242] including, for instance, a report of a maternal death review. Such data and reports can be used by treaty monitoring body members to question reporting governments on what they have done to reduce maternal mortality or morbidity.

b. Complaint and enquiry procedures

Complaint procedures available under different regional and international human rights treaties enable individuals or groups from ratifying countries to bring complaints of alleged violations they have suffered, or experienced less directly, to the relevant treaty monitoring body (see Appendix 10). Successful complaints can have the effect of requiring governments to change or apply laws, or to provide remedies that might benefit individuals as well as groups that are harmed.

A normal condition of tribunals receiving individuals' and private agencies' petitions is that such individuals or agencies have exhausted all reasonable possibilities of achieving remedies before national (often described as "domestic") tribunals of the state against which the petition is presented. This condition respects the legal duties, and rights, of states to afford remedies for wrongs through their own procedures. Once complainants have exhausted domestic procedures available to

them without an adequate remedy, they can then proceed to either regional[243] or international (see Appendix 10)[244] tribunals to claim remedies for alleged violations.

There are several exceptions to the requirement of exhaustion of domestic remedies. For example, the American Convention on Human Rights allows complainants to avoid having to pursue domestic remedies if:

(a) the domestic legislation of the state concerned does not afford due process of law for the protection of the right or rights that have allegedly been violated;
(b) the party alleging violation of rights has been denied access to remedies under domestic law, or has been prevented from exhausting them; or
(c) there has been unwarranted delay in rendering final judgement in cases pursuing domestic remedies.[245]

Once parties have exhausted available means to pursue local remedies, they must choose an appropriate international forum in which to launch their complaint. When choosing, it is always important to consider the full range of options and then decide which will offer the most effective opportunity for redress.

The Optional Protocol to the Women's Convention establishes a procedure of enquiry.[246] This procedure allows CEDAW members to visit a territory, if reliable information indicates grave or systematic violations by a member state of rights under the Convention. This would allow, for example, for visits to appropriate sites to investigate alleged neglect of high rates of preventable maternal mortality.

Outside the treaty regimes is the UN Special Rapporteur on Violence against Women, who has facilitated clarifications of both international and national standards of protection.[247] The UN Commission on Human Rights appointed the Special Rapporteur on Violence Against Women with a broad mandate to eliminate such violence and its causes, and to remedy its consequences by recommending ways and means at national, regional and international levels to eliminate gender violence.[248] Violence against pregnant women that endangers life or enduring health would fall within the Special Rapporteur's mandate.

The Special Rapporteur receives communications about alleged incidents of gender-specific violence against women that have not been effectively addressed through national systems. In ways that are similar to those of an ombudsman working at the domestic level, the Rapporteur uses this information to conduct discussions with governments with a view to finding resolutions.[249] Reports of the Special Rapporteur[250] show that perpetuation of such violence may be an offence by a state itself against a broad range of accepted rights expressed in international human rights treaties already binding on the state in question.

In 1998, the Special Rapporteur on the Status of Women of the Inter-American Commission on Human Rights issued a report on the status of women in the Americas.[251] Moreover, the Inter-American Commission's reports on the situation of human rights in specific countries now devote chapters to the human rights of women. These may identify violations of rights that contribute to unsafe motherhood.

References

CHAPTER I - Introduction

1 World Health Organization, United Nations Children's Fund and United Nations Population Fund. *Maternal mortality in 1995. Estimates developed by WHO, UNICEF and UNFPA.* WHO/RHR/01.9. Geneva, World Health Organization, 2001.

2 United Nations Population Fund. *The State of the World Population 1999, 6 Billion: A Time for Choices*, 1999 at 30.

3 World Health Organization. *Mother-Baby Package Costing Spreadsheet.* WHO/FCH/RHR/99.17. Geneva, World Health Organization, 1999.

4 Starrs A. *The Safe Motherhood Action Agenda: Priorities for the Next Decade. Report on the Safe Motherhood Technical Consultation (Colombo, Sri Lanka, 18-23 October 1997).* New York, Family Care International, 1998.

5 Atrash HK, Alexander S, Berg CJ. Maternal Mortality in Developed Countries: Not Just a Concern of the Past. *Obstetrics and Gynecology*, 1995, 86:700-5.

CHAPTER II – Understanding Unsafe Motherhood

6 Maine D. *Studying Maternal Mortality in Developing Countries: A Guidebook: Rates and Causes*. Geneva, World Health Organization, 1987.

7 18 December 1979, 1249 UNTS 13, *entered into force* 3 September 1981 [hereinafter, *Women's Convention*].

8 Nielsen BB, Liljestrand J, et al. Reproductive Pattern, Perinatal Morality, and Sex Preference in Rural Tamil Nadu, South India: Community Based, Cross Sectional Study. *British Medical Journal*, 1997, 314:1321-1324.

9 Fathalla MF. The Long Road to Maternal Death. People, 1987, 14(3):8-9 and generally Fathalla MF. *From Obstetrics and Gynecology to Women's Health: The Road Ahead*. New York, Parthenon, 1997.

10 International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights. Public Health, An Introduction. In: Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and Human Rights*. New York, Routledge, 1999 at 29-34.

11 World Health Organization. *The Tenth Revision of the International Classification of Diseases (ICD-10)*. Geneva, World Health Organization, 1992.

12 Starrs, *supra* note 4 at 62.

13 World Health Organization, United Nations Children's Fund and United Nations Population Fund, *supra* note 1.

14 Fortney JA, Smith JB. Measuring Maternal Morbidity. In: Berer M, Ravindran TKS, eds. *Safe Motherhood Initiatives: Critical Issues*. Special Edition, Reproductive Health Matters, 1999, 43-50 at 43.

15 *Ibid*.

16 Campbell OMR. Measuring Progress in Safe Motherhood Programmes: Uses and Limitations of Health Outcome Indicators. In: Berer, Ravindran, *supra* note 14, 31-42 at 34.

17 World Health Organization, United Nations Children's Fund and United Nations Population Fund., supra note 1.

18 *Ibid*.
19 *Ibid*.
20 World Health Organization. *Manual for Investigating Maternal Deaths and Severe Complications of Pregnancy*. Geneva, World Health Organization, 2001. (unpublished).
21 *Ibid*.
22 *Ibid*.
23 World Health Organization. *Home-based Maternal Records: Guidelines for Development, Adaptation and Evaluation*. Geneva, World Health Organization, 1994.
24 AbouZahr C, Measuring Maternal Mortality: What Do We Need to Know? In: Berer, Ravindran, *supra* note 14, 13-26 at 18..
25 World Health Organization. *Mother-Baby Package: Implementing Safe Motherhood in Countries.* WHO/FHE/MSM/94.11. World Health Organization, Geneva, 1994.
26 *Ibid*.
27 Maine D, et al. *The Design and Evaluation of Maternal Mortality Programs*. New York, Center for Population and Family Health, School of Public Health, Columbia University, 1997.
28 *Ibid.* at 4.
29 AbouZahr C. Maternal Mortality Overview. In: Murray C, Lopez A, eds. *Health Dimensions of Sex and Reproduction*. Boston, Harvard School of Public Health on Behalf of the World Health Organization and the World Bank, 1998, 111-164 at 149.
30 *Ibid*. at 119.
31 Brabin BJ. *The Risk and Severity of Malaria in Pregnant Women, Applied Field Research in Malaria Reports No.1*. Geneva, World Health Organization, 1991.
32 AbouZahr, in Murray, Lopez, *supra* note 29 at 149.
33 WHO, UNFPA, UNICEF, World Bank, *Reduction of Maternal Mortality. A joint WHO/UNFPA/UNICEF/World Bank Statement.* Geneva, World Health Organization, 1999 at 16.
34 AbouZahr, in Murray, Lopez, *supra* note 29 at 149.
35 *Ibid*. at 150.
36 Kosseim M, Brunham RC. Fallopian tube obstruction as a sequela to Chlamydia trachomatis infection. *European Journal of Clinical Microbiology,* 1986, 5:584-590.
37 Centres for Disease Control. Ectopic pregnancy - United States, 1990-1992. *Morbidity and Mortality Weekly Report*, 1995, 44:46-48.
38 AbouZahr, in Murray, Lopez, *supra* note 29 at 150.
39 Fauveau V, Blanchet T. Deaths from injuries and induced abortion among rural Bangladeshi women. *Social Science and Medicine*, 1989, 29(9):1121-7.
40 Cook RJ, Dickens BM. *Considerations for Formulating Reproductive Health Laws*. 2nd ed. Geneva, World Health Organization, 2000.
41 Cook RJ, Maine D. Spousal Veto over Family Planning Services. *American Journal of Public Health*, 1987, 77:339-44.
42 Packer CAA. Preventing Adolescent Pregnancy: the Protection Offered by International Human Rights Law. *International Journal of Children's Rights*, 1997, 5:46-76.

43 Coliver S, ed. *The Right to Know: Human Rights and Access to Reproductive Health Information*. Philadelphia, University of Pennsylvania Press, 1995.
44 Dickens BM, Cook RJ. Law and Ethics in Conflict over Confidentiality? *International Journal of Gynecology and Obstetrics*, 2000, 70:385-391.
45 Yamin AE, et al. Physicians for Human Rights, Health Care Held Hostage: Violations of Human Rights and Medical Neutrality in Chiapas, Mexico, 29, 1999. Cited in: Yamin AE, Maine DP. Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations. *Human Rights Quarterly*, 1999, 21:563-607 at 599.
46 Doyal L. *Gender and Health: Technical Paper*. Geneva, World Health Organization, 1998 at 6.
47 Campbell OMR, Cleland J, Collumbien M, Southwick K. *Social Science Methods for Research on Reproductive Health*. Geneva, World Health Organization, 1999 at 7.
48 Jejeebhoy SJ. The Importance of Social Science Research in the Promotion of Sexual and Reproductive Choice of Adolescents. *Medicine and Law*, 1999, 18:255-275 at 256.
49 *Ibid*.
50 Kapur R, Cossman B. *Subversive Sites: Feminist Engagements with Law in India*. New Delhi, India, Sage Publications, 1996 at 12.
51 *Ibid*.
52 Shaheed F, Warraich SA, Balchin C, Gazdar A, eds. *Shaping Women's Lives: Laws, Practices and Strategies in Pakistan*. Lahore, Shirkat Gah, 1998.
53 See, for example, Center for Reproductive Law and Policy, and Demus, Estudio para la Defensa de los Derechos de la Mujer. *Women of the World: Laws and Policies Affecting their Reproductive Lives – Latin America and the Caribbean*. New York, Center for Reproductive Law and Policy, 1997; Center for Reproductive Law and Policy, International Federation of Women Lawyers (Kenya Chapter). *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Anglophone Africa*. New York, Center for Reproductive Law and Policy, 1997; Center for Reproductive Law and Policy, Groupe de recherche femmes et lois au Sénégal (GREFELS). *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Francophone Africa* (available in French). New York, Center for Reproductive Law and Policy, 1997.
54 Sagade J. *Raising Age of Marriage: Socio-legal Constraints and Strategies.* Working Paper. Geneva, World Health Organization, forthcoming 2001.
55 Muianga L. Gender, Norms, Cultural Values and the Right to Education: An Example of Three Schools in Manhica District of Mozambique. In: Ncube W, ed. *Law, Culture, Tradition and Children's Rights in Eastern and Southern Africa*. Aldershot, UK, Ashgate/Dartmouth, 1998, 266-288.
56 Heise L, Ellsberg M, Gottemoeller M. Ending Violence Against Women. *Population Reports Series I*, 1999, 11:9-18.
57 Armstrong A. Consent and Compensation: The Sexual Abuse of Girls in Zimbabwe. In: Ncube, *supra* note 55 at 129-149.
58 Heise, Ellsberg, Gottemoeller, *supra* note 56 at 10-11.
59 Berg C, Danel I, Mora G. *Guidelines for Maternal Mortality Epidemiological Surveillance*. Washington, Pan American Health Organization, 1996 at 17.

60 *Ibid.*
61 UNICEF. *A Human Rights Approach to UNICEF: Programming for Children and Women: What It Is, and Some Changes It Will Bring*. New York, UNICEF, 1998 at 34.

CHAPTER III – Human Rights Affecting Safe Motherhood

62 For citations to the legal literature regarding the international protection of women's reproductive rights, see Women's Human Rights Resources website, Bora Laskin Law Library, University of Toronto, at http://www.law.utoronto.ca/diana.
63 10 December 1948, G.A. Res. 217A (III), UN Doc A/810, at p. 71.
64 *The Women's Convention*, *supra* note 7.
65 16 December 1966, 999 UNTS 171, *entered into force* 23 March 1976.
66 16 December 1966, 993 UNTS 3, *entered into force* 23 March 1976.
67 21 December 1965, 660 UNTS 195, *entered into force* 4 January 1969.
68 20 November 1989, 1577 UNTS 3, *entered into force* 2 September 1990.
69 4 November 1940, 213 UNTS 222, *entered into force* 3 September 1953, as amended by Protocol Nos. 3, 5 and 8, *entered into force* 21 September 1970, 20 December 1971 and 1 January 1990, respectively.
70 (1996) E.T.S. No. 163, *entered into force* 1999.
71 (1969) O.A.S.T.S. 1, *entered into force* 18 July 1978.
72 O.A.S.T.S. No. 69 (1988), signed Nov 17, 1988. Reprinted in: Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser. L. V./II.82, doc. 6 rev. 1 at p. 67 (1992).
73 Known as the *Convention of Belém do Pará* for the place of its adoption, opened for signature June 9, 1994, *entered into force* March 5, 1995, OAS Treaties Register A 61; 33 I.L.M. 1534 (1994).
74 27 June 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982), *entered into force* 21 October 1986.
75 United Nations. *Report of the International Conference on Population and Development, Cairo, Egypt, 13-15 September 1994*. UN Doc. A/Conf. 171/13, 1994 [hereinafter, *Cairo Programme*].
76 United Nations. *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*. UN GAOR, 1999, UN Doc. A/Res/S-21/2, at para. 47. This document is available at http://www.unfpa.org/icpd/icpdmain.htm [hereinafter, *Cairo Plus Five*].
77 United Nations. *Report of the Fourth World Conference on Women, Beijing, China, 4-15 September 1995*. UN Doc. A/Conf. 177/20, 1995 [hereinafter, *Beijing Platform*].
78 United Nations. *Report of the Ad Hoc Committee of the Whole of the Twenty-third Special Session of the General Assembly, Further actions and initiatives to implement the Beijing Declaration and Platform for Action*, UN GAOR, 2000, UN Doc. A/S-23/10/Rev.1.
79 McChesney A. *Promoting and Defending Economic, Social and Cultural Rights: A Handbook*. Washington, D.C., American Association for the Advancement of Science, 2000; O'Flaherty M. *Human Rights and the UN:*

Practice Before the Treaty Bodies. London, Sweet & Maxwell, 1996; United Nations. *Manual on Human Rights Reporting*. New York, United Nations, 1997.

80 Alston P. The International Covenant on Economic, Social and Cultural Rights. In: *Manual on Human Rights Reporting*. New York, United Nations, 1997, 65-169.

81 *The Children's Convention*, *supra* note 68, Article 44.

82 *The Race Convention*, *supra* note 67, Article 9.

83 *The Women's Convention, supra* note 7, Article 12.

84 See, for instance, Boerefijn I, Toebes B. *Health and Human Rights, Health Issues discussed by the United Nations Treaty Monitoring Bodies*. Netherlands Institute for Human Rights, SIM Special Issue 21, 1998, 25-53; McDonald K, Stanchieri J, Merali I, Cook RJ. *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of The Work of UN Treaty Bodies, International Programme on Reproductive and Sexual Health Law*. Toronto, Faculty of Law, University of Toronto & Ottawa, Action Canada for Population and Development (forthcoming 2001).

85 United Nations. *International Human Rights Instruments: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*. HRI/Gen/1/Rev.4, 7 February 2000.

86 United Nations, Human Rights Committee. *Revised Guidelines Regarding the Form and Contents of Periodic Reports from States Parties.* UN GAOR, 1995, UN Doc. 4/50/40, Annex VII at 140.

87 United Nations, Committee on Economic, Social and Cultural Rights. *General Comment 3, The Nature of States Parties Obligations*. In Human Rights Instruments, *supra* note 85 at 9, para 10.

88 *Race Convention, supra* note 67, Article 14.

89 United Nations. *Optional Protocol to the International Covenant on Civil and Political Rights*. 999 UNTS 302, *entered into force* 23 March 1976.

90 United Nations. *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women*. UN Doc. A/Res/54/4, *entered into force* 22 December 2000.

91 See Part II, above, Understanding Unsafe Motherhood.

92 United Nations, Human Rights Committee. *General Comment 6, Article 6 (Right to Life)*. In: Human Rights Instruments, *supra* note 85 at 85.

93 *Ibid*.

94 *Tavares v. France* (1991), Eur. Comm. H.R., Application No. 16593/90, (09/12/91 unpublished).

95 *European Convention, supra* note 69, Article 2 reads: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court of law following his conviction of a crime for which this penalty is provided by law."

96 *X v. United Kingdom* (1978), Eur. Comm. H.R., Application No. 7154, Decision 12 July 1978. European Commission of Human Rights, Decision & Reports 14:31-35, June 1979.

97 *Cairo Programme, supra* note 75 at para. 7.2.

98 See *infra* III.D. Performance Standards.

99 Article 21 of the Indian Constitution, on the Protection of Life and Personal Liberty, reads: "No person shall be deprived of his life or personal liberty except according to procedure established by law."
100 *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) 4 SCC 37; (1996) 3 SCJ 25, digested in (1998) 2 Commonwealth Human Rights Law Digest 109 (India).
101 Article 58 of the 1961 Venezuelan Constitution reads: "The right to life is inviolable…."
102 Article 76 of the 1961 Venezuelan Constitution reads:
"Everyone shall have the right to protection of his health. The authorities shall oversee the maintenance of public health and shall provide the means of prevention and attention for those who lack them. Everyone is obliged to submit to health measures established by law, within the limits imposed by respect for the human person."
103 *Cruz Bermudez, et al. v. Ministerio de Sanidad y Asistencia Social (MSAS)*, Case No. 15789 http://www.csj.gov.ve (last visited 13 June 2000) (Venezuela).
104 Inter-American Commission of Human Rights. *Annual Report*, 1980-1981 at 125. Cited in: *Annual Report*, 1989-1990 at 187.
105 Ministerio de Salud, DANE, Presidencia de la República, DNP, OPS, UNFPA, UNICEF, PROFAMILIA. Por qué se mueren las mujeres en Colombia? In *Revista PROFAMILIA*, 1996, 14(28).
106 *Cairo Programme*, *supra* note 75 at para. 7.2.
107 *R v. Morgentaler* (1988), 44 D.L.R. (4th) 385 (S.C.C.) (Canada).
108 *Judgement of Jan. 15, 1975*, Conseil Constitutionnel, 1975 Recueil Dalloz-Sirey [D.S. Jur.] 529, Journal Officiel, Jan. 16, 1975 (France).
109 *Judgement No.108/81 of 25 June 1981*, Corte Costituzionale, 57 Raccolta Ufficiale della Corte Costituzionale 823, 1981 (Italy).
110 *Juristenvereiniging Pro Vita v. De Staat der Nederlanden (Ministerie van Welzijn, Volksgezondheid en Cultuur)* [1990] NJ 2986 (Hof, The Hague, 8 February 1990) (Netherlands).
111 D v. United Kingdom (1997), Eur. Ct. H.R., 24 E.H.R.R. 423.
112 *Williams v. Jamaica*, Comm. No. 609/1995, UN Doc. CCPR/C/61/D/609/1995 (17 November 1997).
113 United Nations, Human Rights Committee. *Concluding Observations on Peru: 11/18/96.* UN Doc. CCPR/C/79/Add.72 at para. 15.
114 *Ibid*. at para. 19.
115 *Ibid.* at para. 22.
116 Article VII, American Declaration of the Rights and Duties of Man,1948; O.A.S. Res. XXX, adopted by the Ninth International Conference of American States, 1998. Reprinted in *Basic Documents Pertaining to Human Rights in the Inter-American System*, OEA/Ser.L.V/II.82, doc. 6, rev. 1, 1992 at p. 17.
117 See *infra* III.D. Performance Standards.
118 *Convention concerning the Employment of Women before and after Childbirth*, 28 November 1919, I.L.O. Convention C3, 38 UNTS 53, *entered into force* 13 June 1921, revised in 1952.
119 *Convention concerning Maternity Protection (revised)*, 28 June 1952, I.L.O. Convention C103, 214 UNTS 321, *entered into force* 7 September 1955.

120 *Recommendation concerning Maternity Protection*, No. 95, 28 June 1952, I.L.O. Recommendation R95. International Labour Conventions and Recommendations, Volume 2, Geneva, International Labour Office, 1996, at 44.
121 International Labour Office. *Report V(1): Maternity Protection at Work - Revision of the Maternity Protection Convention (Revised), 1952 (No. 103),* and *Recommendation, 1952 (No. 95).*
122 *Ibid.*
123 *Ibid.* at 29.
124 *Convention concerning Maternity Protection (Revised), 2000*, 15 June 2000, I.L.O. Convention C183.
125 *Recommendation Concerning Maternity Protection, 2000*, 15 June 2000, I.L.O. Recommendation R191.
126 United Nations, Human Rights Committee. *Concluding Observations on India: 04/08/97*. UN Doc. CCPR/C/79/Add.81 at para.16.
127 Pendse V. Maternal Deaths in an Indian Hospital: A Decade of (No) Change? In: Berer, Ravindran, *supra* note 14, 119-126.
128 United Nations, Committee on the Elimination of Discrimination Against Women. *Concluding Observations on Nepal: 01/07/99*. UN Doc. CEDAW/C/1999/L.2/Add.5 at para. 37**.**
129 Starrs, *supra* note 4 at 16.
130 World Health Organization. *Obstetric Fistulae: A Review of Available Information*. WHO/MCH/MSM/91.5. Geneva, World Health Organization, 1991.
131 *Ibid*. at 3.
132 *Ibid.*
133 Bangser M, Gumodoka B, Berege Z. A Comprehensive Approach to Vesico-Vaginal Fistula: A Project in Mwanza, Tanzania. In: Berer, Ravindran, *supra* note 14, 157-165 at 158.
134 United Nations, Committee on Economic, Social and Cultural Rights. *Concluding Observations on Suriname: 07/06/95*. UN Doc. E/C 12/1995/6 at para.16.
135 United Nations, Committee on Economic, Social and Cultural Rights. *Concluding Observations on Cameroon: 08/12/99*. UN Doc. E/C.12/1/Add.40 at para.14.
136 *Re Miriam Willingal* (10 Feb 1997), MP No 289 of 1996 (unreported), digested in (1998) 2 Commonwealth Human Rights Law Digest (CHRLD) 57 (Papua New Guinea).
137 United Nations, Committee on the Elimination of Discrimination Against Women. *General Recommendation 21, Equality in Marriage and Family Relations*. In: Human Rights Instruments, *supra* note 85 at 173.
138 *Ibid*. at para 16.
139 Article 39, the Constitution of the Republic of Ecuador, 11 August 1998.
140 Cook RJ, Dickens BM, Bliss LE. International Developments in Abortion Law from 1988 to 1998. *American Journal of Public Health*, 1999, 89:579-586.
141 *Paton v. United Kingdom* (1980), Eur. Comm. H.R., 3 E.H.R.R. 408.
142 Cook RJ. International Protection of Women's Reproductive Rights. *New York University Journal of International Law and Politics*, 1992, 24:645- 727 at 706.

143 Family Health Division, Dept. of Health Services, Ministry of Health, Nepal. *Maternal Mortality and Morbidity Study*, 1998, at p. ii.
144 Brazilian Constitution, 5 October 1988 as amended to 4 June 1998, Art. 196.
145 See *infra* III.D. Performance Standards.
146 WHO, UNICEF, UNFPA. *Women-Friendly Health Services: Experiences in Maternal Care*. Report of a WHO / UNICEF / UNFPA Workshop, Mexico City, 26-28 January 1999.
147 United Nations, Committee on Economic, Social and Cultural Rights. *Concluding Observations on Gambia: 31/05/94*. UN Doc. E/C.12/1994/9 at para. 16.
148 Boerefijn, Toebes, *supra* note 84.
149 South African Constitution at section 27(3). Section 27 of the South African Constitution provides that:
"(1) Everyone has the right to have access to -
(a) health care services, including reproductive health care;
…
(2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of these rights.
(3) No one may be refused emergency medical treatment."
150 *Soobramoney v. The Minister of Health, Kwazulu Natal*, 1998 (1) SA 765 (CC).
151 *Ibid.* at 771.
152 *Ibid.* at 774.
153 Starrs, *supra* note 3 at 17, based on a presentation by Tinker A. *Safe Motherhood as an Economic and Social Investment*. Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October, 1997, Colombo, Sri Lanka.
154 Starrs, *ibid.* at 17.
155 *Ibid.* at 16.
156 *Ibid.* at 15-16.
157 Weissman E, Sentumbwe-Mugisa O, Mbonye AK, Lissner C. Costing Safe Motherhood in Uganda. In: Berer, Ravindran, *supra* note 14, 85-91.
158 Schneider H, Gibson L. The Impact of Free Maternal Health Care in South Africa. In: Berer, Ravindran, *supra* note 14, 93-101 at 100.
159 Graham WJ, Murray FS, Taylor C. A Question of Survival: I. A Review of Safe Motherhood in Kenya: II. Two Years After the Review: Accomplishments, Hurdles and Next Steps. In: Berer, Ravindran, *supra* note 14, 102-116 at 108.
160 Starrs, *supra* note 3 at 42.
161 See *infra* III.C.3.A. Sex and Gender.
162 Leary V. Justiciability and Beyond: Complaint Procedures and the Right to Health. *The Review*, 1995, 55:105 at 115.
163 *Feldbrugge v. The Netherlands* (1985), Eur. Ct. H.R. Ser. A, No. 99, 8 E.H.R.R. 149.
164 Cook RJ. Human Rights Law and Safe Motherhood. *European J. of Health Law*, 1998, 5:357-375.
165 *Aumeeruddy-Cziffra et al. v. Mauritius*, Comm. No. 35/1978, UN Doc. A/36/40 (1981).
166 See *infra* III.C.2.iii. *The Right To Marry and To Found a Family*.
167 United Nations, Committee on the Rights of the Child. *Concluding Observations on Mexico: 10/11/99*. UN Doc. CRC/C/15/Add.112 at para.16.

168 United Nations, Committee on the Elimination of Discrimination Against Women, *Concluding Observations on Guatemala: 12/04/94*. UN Doc. A/49/38 at para.71.
169 UNFPA. *Promoting Gender Equality in Population and Development Programmes: Best Practices and Lessons Learned*. New York, UNFPA, 1999 at 5.
170 United Nations, Committee on the Elimination of Discrimination Against Women, *Concluding Observations on Indonesia: 14/05/98*. UN Doc. A/53/38 at para. 284.
171 United Nations, Committee on the Elimination of Discrimination Against Women, *Concluding Observations on Venezuela: 27/01/97*. UN Doc. A/52/38/Rev.1 at para. 236.
172 United Nations, Committee on Economic, Social, and Cultural Rights. *Concluding Observations on Paraguay: 28/05/96*. UN Doc. E/C.12/1/Add.1 at para. 16.
173 *Broeks v. The Netherlands*, Communications No. 172/1984, 42 UN GAOR, 1987, UN Doc. A/42/40 at 139.
174 United Nations, Committee on the Elimination of Discrimination Against Women. *Concluding Observations on Dominican Republic, 14/05/98*. UN Doc. A/53/38 at para. 332.
175 Packer, *supra* note 42.
176 World Bank. *World Development Report 1993 – Investing in Health*. New York, Oxford University Press, 1993 at 84-117.
177 *Children's Convention*, *supra* note 68, Article 14 (2).
178 Cook RJ, Dickens BM. Recognizing Adolescents' 'Evolving Capacities' to Exercise Choice in Reproductive Health Care. *Int'l Journal of Gynecology and Obstetrics, World Report on Women's Health - Year 2000*, 2000, 70(1):13-21.
179 United Nations, Committee on the Rights of the Child. *Concluding Observations on Nicaragua: 20/06/95*. UN Doc. CRC/C/15/Add.36, 1995 at para. 19.
180 *Ibid.* at para. 35.
181 United Nations, Committee on the Elimination of Discrimination Against Women. *Concluding Observations on Saint Vincent and the Grenadines: 22/01/97*. UN Doc. A/52/38/Rev.1 at para. 147.
182 Atrash, *supra* note 5.
183 *Ibid.*
184 Mungra A. *Confidential Enquiries into Maternal Deaths in Surinam.* The Netherlands, Pasmans Offsetdrukkerij bv, Den Haag, 1999 at 112.
185 AbouZahr, in Berer, Ravindran, *supra* note **Error! Bookmark not defined.** at 150.
186 *Case 7615 (Brazil) (1985)*, Inter-Am. Comm. H.R. Res. No. 12/85, Annual Report of the Inter-American Commission on Human Rights, 1984-85.
187 Article XI, American Declaration of the Rights and Duties of Man, *supra* note 116.
188 United Nations, Committee on the Elimination of All Forms of Racial Discrimination. *Concluding Observations on Cambodia: 31/03/98*. UN Doc. CERD/C/304/Add.54 at para. 18.

189 United Nations, Committee on the Elimination of Racial Discrimination. *General Recommendation XIV, Article 1 (definition of racial nondiscrimination).* In Human Rights Instruments, *supra* note 85, 95-96 at para 2.
190 Yamin, *supra* note 45.
191 Coliver S. The Right to Information Necessary for Reproductive Health and Choice Under International Law. In: Coliver, *supra* note 43.
192 *Women's Convention, supra* note 7, Article 10(h).
193 Coliver, *supra* note 43.
194 *Open Door Counselling and Dublin Well Women* v. *Ireland* (1992), Eur. Ct. H.R. Ser. A, No. 246, 15 E.H.R.R. 244.
195 *Ibid.* at para. 77.
196 UNICEF. *Programming for Safe Motherhood: Guidelines for Maternal and Neonatal Survival*. New York, UNICEF, 1999 at 26-27.
197 *Unni Krishnan v. State of Andhra Pradesh*, A.I.R. 1993 S.C. 2178 at 2197; see also *Mohini Jain v. State of Karnataka*, A.I.R. 1992 S.C. 1858; (1992) 3 S.C.C. 666 (India).
198 Unni Krishnan, ibid. at 2231.
199 *R. v. Birmingham City Council*, [1989] 2 W.L.R. 520 (H.L) (U.K.), digested in (1989) 15 Commonwealth Law Bulletin 414 (United Kingdom).
200 *Kjeldsen v. Denmark* (1976), Eur. Ct. H.R. Ser. A, No. 23, 1 E.H.R.R. 711 at para. 53.
201 Nga DTN, Morrow M. Nutrition in Pregnancy in Rural Vietnam: Poverty, Self Sacrifice and the Fear of Obstructed Labour. In: Berer, Ravindran, *supra* note 14, 137-146 at 137.
202 *Programming for Safe Motherhood, supra* note 196 at 50.
203 *Paschim Banga, supra* note 100.
204 *Cairo Plus Five, supra* note 76, para 64.
205 United Nations. *Report of the Committee on the Elimination of Discrimination Against Women (14th Session)*. UN GAOR, 1995, UN Doc. A/50/38 at 11-12.
206 World Health Organization. *Monitoring Reproductive Health: Selecting a Short List of National and Global Indicators*. WHO/RHT/HRP/97.26. Geneva, World Health Organization, 1997.
207 See *supra* III.C.B. The Right to the Highest Attainable Standard of Health.
208 World Health Organization. *Monitoring Reproductive Health: Selecting a Short List of National and Global Indicators, supra* note 206 at 3.
209 World Health Organization. *Coverage of Maternity Care, A Listing of Available Information, supra* note 25.
210 Cairo Plus Five, *supra* note 76 at para. 47.
211 Maine D, Wardlaw TM, Ward VM, McCarthy J, Birnbaum A, Akalin MZ, Brown JE. *Guidelines for Monitoring the Availability and Use of Obstetric Services.* 2nd ed. New York, UNICEF, 1997 [hereinafter UN Guidelines].
212 Yamin, Maine, *supra* note 45.
213 Maine et al, *supra* note 211.
214 *Ibid*. at 24.
215 *Ibid.* at 34-36.
216 Yamin, Maine, *supra* note 45 at 577-581.

CHAPTER IV – Strategies for Implementation

217 Article 48(1)(f) of the American Convention, *supra* note 71; see also Articles 49-51.
218 Inter-American Commission on Human Rights. Regulations of the Inter-American Commission on Human Rights, approved by the Commission at its 660th meeting, 49th Session, held April 8, 1980, as last modified at its 92nd Special Session, 1311th Meeting, held May 3, 1996.
219 See, for example, World Health Organization. *Preventing Maternal Deaths.* Geneva, World Health Organization, 1989.
220 Fisher R, Ury W, Patton B. *Getting to YES.* 2d ed. New York, Penguin Books, 1991 at 73.
221 World Bank. *Safe Motherhood and The World Bank: Lessons from 10 Years of Experience*. Washington, The World Bank, 1999.
222 Fisher, Ury, Patton, *supra* note 220 at 47.
223 Cook RJ. Fostering Compliance with Reproductive Rights. In: Sadik N, ed. *UNFPA Plus Thirty*. New York, New York University Press, forthcoming 2001.
224 Jabine TB, Claude RP, eds. *Human Rights and Statistics: Getting the Record Straight*. Philadelphia, University of Pennsylvania Press, 1992.
225 Orentlicher DF. Bearing Witness: The Art and Science of Human Rights Fact Finding. *Harvard Human Rights Journal*, 1990, 3:83-135 at 83.
226 World Health Organization. *Unsafe Abortion: Global and Regional Estimates of Incidence of and Mortality Due to Unsafe Abortion with a Listing of Available Country Data*. Geneva, World Health Organization, 1998.
227 United Nations. *The World's Women: 2000 Trends and Statistics*, New York, United Nations 2000; United Nations. *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual*. UN High Commissioner for Refugees, 1996.
228 See, for example, Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), Center for Reproductive Law and Policy (CRLP). *Silence and Complicity: Violence Against Women in Peruvian Public Health Facilities*. 1999 (also available in Spanish); The Women's Rights Project of Human Rights Watch. *Criminal Injustice: Violence Against Women in Brazil*. New York, Human Rights Watch, 1991 (also available in Portuguese).
229 Jabine, Claude, *supra* note 224.
230 Reilly N. *Without Reservation: The Beijing Tribunal on Accountability for Women's Human Rights*. New Jersey, Center for Women's Global Leadership, Rutgers University, 1996.
231 Jabine, Claude *supra* note 224.
232 *Ibid.* at 9-10.
233 Ahmed An-Na'im A, ed. *Universal Rights, Local Remedies: Implementing Human Rights in the Legal Systems of Africa*. London, Interights, 1999.
234 Kismodi E. The Ombudsman Approach to the Protection of Reproductive Rights in Hungary. *Medicine and Law*, 1999, 18(2,3):305-311.
235 International Women's Rights Action Watch. *The Women's Watch*, 1998, 12(2,3):7.

236 Canadian Human Rights Foundation and Philippine Commission on Human Rights. *The Role of National Human Rights Commissions in the Promotion and Protection of Economic, Social and Cultural Rights*. Montreal, Canadian Human Rights Foundation, 1999.

237 Constitution of Colombia, Art. 93: "International treaties and agreements ratified by the Congress that recognize human rights and that prohibit their limitation in states of emergency have priority domestically."

238 Shelton D. The Promise of Regional Human Rights Systems. In: Weston BH, Marks SP, eds. *The Future of International Human Rights*. New York, Transnational Publishers, 1999, 351-391; Calderon MC, Plata MI, Stanchieri J, Merali I, Cook RJ. *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of the Inter-American Human Rights System*. International Programme on Reproductive and Sexual Health Law, Faculty of Law, University of Toronto & PROFAMILIA Legal Services, forthcoming 2001; Rasmussen N, Bogecho D, Stanchieri J, Merali I, Cook RJ. *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of the European Human Rights System*. International Programme on Reproductive and Sexual Health Law, Faculty of Law, University of Toronto & the Danish Center for Human Rights, forthcoming 2001; Carbert A, Stanchieri J, Merali I, Cook RJ. *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of the African Human Rights System*. International Programme on Reproductive and Sexual Health Law, Faculty of Law, University of Toronto, forthcoming 2001.

239 McDonald, Stanchieri, Merali, Cook, *supra* note 84.

240 McChesney; O'Flaherty; United Nations, *supra* note 79.

241 For a helpful resource on the preparation of shadow reports, *see* www.igc.org/iwraw/. See also, International Women's Rights Action Watch. *Assessing the Status of women – A Guide to Reporting under the Convention on the Elimination of All Forms of Discrimination Against Women*. 2nd ed. London, Commonwealth Secretariat, 1996.

242 See for instance, CEDAW Alternative Report by Indian NGOs: Article 12 Health Care, CHETNA, Ahmedabad, India, cited in: *Women's International News Network* 23 (3): 23-24 (1997); Center for Reproductive Law and Policy, Association des Femmes Juristes du Bénin. *Reproductive Rights of Young Girls and Adolescents in Benin: A Shadow Report*. 1999; Latin American and Caribbean Committee for the Defense of Women's Rights, the Center for Reproductive Law and Policy, Estudio para la Defensa de los Derechos de la Mujer. *Women's Sexual and Reproductive Rights in Peru: A Shadow Report*. 1998; Center for Reproductive Law and Policy, Women's Legal Aid Centre. *Women's Reproductive Rights in Tanzania: A Shadow Report*. 1998.

243 See http://www.cidh.oas.org/email.htm for a model communication to the Inter-American Commission on Human Rights.

244 See www.unhchr.ch/html/menu2/complin.htm for further information on United Nations Committees' communications and complaints procedures; See http://www.commat.org for overview of upcoming UN treaty body sessions and which countries are due to report.

245 *American Convention*, *supra* note 71, Article 46 (2).

246 *The Optional Protocol to the Women's Convention*, *supra* note 90, Article 8.

247 See www.unhchr.ch/html/menu2/7/b/women/womform.htm for the Confidential Violence Against Women Information Form for the Special Rapporteur on Violence Against Women.
248 Commission on Human Rights – Special Rapporteur. *Violence Against Women, Its Causes and Consequences.* UN Doc. E/CN.4/1995/42, 22 Nov 1994.
249 Commission on Human Rights – Special Rapporteur. *Violence Against Women, Its Causes and Consequences.* UN Doc. E/CN.4/1997/47/Add.4, 30 Jan 1997.
250 See particularly country mission reports of the Special Rapporteur: *Report on the Mission to Brazil on the issue of domestic violence*. UN Doc. E/CN.4/1997/47/Add.2, 21 Jan 1997; *Report on the mission to South Africa on the issue of rape in the community*. UN Doc. E/CN.4/1997/47/Add.3, 24 Feb 1997.
251 Inter-American Commission on Human Rights. *Report of the Inter-American Commission on Human Rights on the Status of Women in the Americas*. OEA/Ser.L/V/II.100, Doc. 17, 13 October 1998.

Appendix 1

Lifetime Risk Data (Selected Countries)

> **Lifetime Risk:** This measure reflects the probability of maternal death faced by an average woman over her entire reproductive lifespan. Like the maternal mortality rate, it reflects both a woman's risk of dying from maternal death, as well as her risk of becoming pregnant. However, it also takes into account the accumulation of risk with each pregnancy.

Women's Lifetime Risk of Maternal Death

Africa		***1 in 14***
e.g.	Angola	1 in 9
	Benin	1 in 15
	Burkina Faso	1 in 9
	Cameroon	1 in 21
	Chad	1 in 9
	Congo	1 in 12
	Congo, Democratic Republic of the	1 in 13
	Côte d'Ivoire	1 in 13
	Ethiopia	1 in 7
	Kenya	1 in 13
	Mali	1 in 19
	Mozambique	1 in 13
	Nigeria	1 in 14
	Rwanda	1 in 6
	Senegal	1 in 12
	Sierra Leone	1 in 6
	South Africa	1 in 70
	Sudan	1 in 12
	Tanzania, United Republic of	1 in 14
	Uganda	1 in 11
	Zambia	1 in 17
	Zimbabwe	1 in 33

South-east Asia		***1 in 47***
e.g.	Bangladesh	1 in 42
	Bhutan	1 in 30
	India	1 in 55
	Indonesia	1 in 65
	Myanmar	1 in 190
	Thailand	1 in 1100
The Americas		***1 in 240***
e.g.	Argentina	1 in 370
	Bolivia	1 in 33
	Brazil	1 in 130
	Canada	1 in 8700
	Colombia	1 in 240
	Dominican Republic	1 in 250
	Ecuador	1 in 120
	El Salvador	1 in 130
	Guatemala	1 in 60
	Haiti	1 in 16
	Honduras	1 in 80
	Jamaica	1 in 280
	Mexico	1 in 430
	Nicaragua	1 in 70
	Paraguay	1 in 110
	Peru	1 in 110
	United States of America	1 in 3500
	Venezuela	1 in 630
Western Pacific		***1 in 490***
e.g.	Cambodia	1 in 29
	China	1 in 710
	Japan	1 in 4600
	Malaysia	1 in 630
	New Zealand	1 in 2600
	Papua New Guinea	1 in 45
	Philippines	1 in 90
	Viet Nam	1 in 290

Eastern Mediterranean		***1 in 60***
e.g.	Afghanistan	1 in 15
	Egypt	1 in 130
	Iraq	1 in 41
	Pakistan	1 in 80
	Tunisia	1 in 430
	Yemen	1 in 13
Europe		***1 in 1300***
e.g.	Armenia	1 in 1500
	Belgium	1 in 6500
	Denmark	1 in 3300
	Germany	1 in 5300
	Hungary	1 in 2300
	Ireland	1 in 4900
	Kazakhstan	1 in 450
	Romania	1 in 1000
	United Kingdom	1 in 4600
Least developed countries		***1 in 16***
Developing countries		***1 in 61***
Industrialized countries		***1 in 4085***

Source:

World Health Organization, United Nations Children's Fund and United Nations Population Fund. *Maternal mortality in 1995. Estimates developed by WHO, UNICEF and UNFPA.* WHO/RHR/01.9. Geneva, World Health Organization, 2001.

Table: Human rights relating to safe motherhood
(The numbers show the relevant provisions of the international instruments [top line] that relate to the named right [left column])

	International/Regional Instruments											
Rights	Universal Declaration of Human Rights	Int'l Covenant on Civil & Political Rights	Int'l Covenant on Economic, Social & Cultural Rights	Int'l Convention on Elimination of All Forms of Racial Discrimination	Convention on Elimination of All Forms of Discrimination against Women	Convention on the Rights of the Child	European Convention on Human Rights and its Protocols & Social Charter	American Convention on Human Rights & Its Protocol	Inter-American Convention on the Prohibition of Violence Against Women	African Charter on Human & Peoples' Rights	Cairo Programme of Action [Cairo +5, 1999]	Beijing Declaration & Platform for Action [Beijing +5, 2000]
LIFE, SURVIVAL AND SECURITY												
Right to Life and Survival	3	6				6	2	4	4(a)	4	Principle 1 8.21-8.27	*See generally* 89-111, 210-233 [72]
Right to Liberty & Security	3	9		5(b)		37(b)-(d)	5	7	4(c)	6	Principle 1 7.2-7.11	*See generally* 89-111, 210-233 [13-14,59, 68(2), 69, 70]
Right to be Free from Inhuman and Degrading Treatment	5	7				37(a)	3	5	3, 4(d)	5	Principle 4 4.9, 4.10, 4.22, 4.23	*See generally* 112-130
MATERNITY												
Right to Maternity Protection	25(2)		10(2)		5(b), 12(2)	24(d)	Charter: 8	26 Protocol: 15, 3(a) (b)			8.19-8.24 [62, 64-66]	94-95, 97, 110-111 [11-12, 72-79]
Right to Marry and Found a Family	16	23	10	5(d)(iv)	16		12	17	5	18, 27(1) (duty)	Principle 9 4.21, *See generally* Ch. V, 7.12-7.23	92, 274(e), 275(b), *See generally* 210-233 [60]

	International/Regional Instruments											
Rights	Universal Declaration of Human Rights	Int'l Covenant on Civil & Political Rights	Int'l Covenant on Economic, Social & Cultural Rights	Int'l Convention on Elimination of All Forms of Racial Discrimination	Convention on Elimination of All Forms of Discrimination against Women	Convention on the Rights of the Child	European Convention on Human Rights and its Protocols & Social Charter	American Convention on Human Rights & Its Protocol	Inter-American Convention on the Prohibition of Violence Against Women	African Charter on Human & Peoples' Rights	Cairo Programme of Action [Cairo +5, 1999]	Beijing Declaration & Platform for Action [Beijing +5, 2000]
Right to Private and Family Life	12	17	10		16	16	8 Charter: 16, 19, 27	11	4(e)	4, 5, 18, 29(1) (duty)	Principle 9 *See generally* Ch. V, 7.12-7.26	*See generally* 210-233
HEALTH												
Right to Highest Standard of Health	25		12	5(e)(iv)	11(1-f) 12 14(2-b)	24	Charter: 3, 11, 13	26 Protocol: 9, 10, 11	5	16	Principle 8, *See generally* Chs. VII, VIII [52-72]	*See generally* 89-111 [11-12, 44, 72, 79]
Right to Procedural Fairness	6, 9, 10, 11	14, 15, 16		5(a)	15	12(2), 37(d), 40	6, 7	3, 8	4(g)	7	Chs. IV, VII, VIII	*See generally* 181-195
Right to Benefits of Scientific Progress	27		15					26; Protocol: 9, 10	5	22	*See generally* Ch. XII	*See generally* 89-111
NON-DISCRIMINATION AND DUE RESPECT FOR DIFFERENCE												
Sex and Gender	1, 2, 7	2(1), 3, 26	2(2), 3		1, 2, 3 4, 5	2(1)	14 Charter: E	1, 24 Protocol: 3	4(f), 6	2, 3, 18(3), 19, 28 (duty)	Principle 1, Principle 4, 4.24-4.29 [39-41, 49-50]	97, 277(c), *See generally* 210-233 [26-27, 52-53, 68]

	International/Regional Instruments											
Rights	Universal Declaration of Human Rights	Int'l Covenant on Civil & Political Rights	Int'l Covenant on Economic, Social & Cultural Rights	Int'l Convention on Elimination of All Forms of Racial Discrimination	Convention on Elimination of All Forms of Discrimination against Women	Convention on the Rights of the Child	European Convention on Human Rights and its Protocols & Social Charter	American Convention on Human Rights & Its Protocol	Inter-American Convention on the Prohibition of Violence Against Women	African Charter on Human & Peoples' Rights	Cairo Programme of Action [Cairo +5, 1999]	Beijing Declaration & Platform for Action [Beijing +5, 2000]
Marital Status	1, 2, 7	2(1), 26	2(2)		1		14 Charter: E	1, 24 Protocol: 3	4(f), 6	2, 3, 18(3), 19, 28	Principle 1, 7.3, 7.7, 7.8, 7.12, 7.14 [49]	*See generally* 89-111, 210-233
Age	1, 2, 7	2(1), 26	2(2)			2(2)	14 Charter: E	1, 24 Protocol: 3	4(f), 6	2, 3, 18(3), 19, 28	Principle 1, *See generally* Chs. IV, VII, 8.12-8.27 [42, 73, 74]	*See generally* 259-285 [32-33]
Race and Ethnicity	1, 2, 7	2(1), 26	2(2)	1, 2, 3, 4		2(1)	14 Charter: E	1, 24 Protocol: 3	4(f), 6	2, 3, 18(3), 19, 28	Principle 1, 6.21-6.27, 7.3, 7.7, 7.8, 7.12, 7.14]	*See generally* 89-111, 210-233 [66(B)]
INFORMATION AND EDUCATION												
Right to Receive & Impart Information	19	19		5(d-viii)	10(h) 14(2-b), 16(1-e)	12, 13, 17	10	13	5	9	8.26 *See generally* Ch. XI	*See generally* 69-111, 210-233
Right to Education	26		13, 14	5(e-v), 7	10, 14(2-d)	28, 29	Protocol 1: 2	26 Protocol: 13	5, 6(b)	17	Principle 10, 4.2, *See generally* Chs. VII, VIII, XI [34-36]	*See generally* 69-88, 210-233 [9-10, 55, 67]

Appendix 3

States Parties to Human Rights Treaties

16 November 2000

x = ratification, accession, notification of succession, acceptance or definitive signature

s = signature not yet followed by ratification

International Treaties

To check the current ratification status of international human rights treaties, see: www.untreaty.org, or United Nations. *Multilateral Treaties Deposited with the Secretary General.* (New York: United Nations, Office of Legal Affairs 1982-), December 1999.

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Afghanistan	x		x	x	s		x
Albania	x		x	x	x		x
Algeria	x	x	x	x	x		x
Andorra					x		x
Angola	x	x	x		x		x
Antigua and Barbuda				x	x		x
Argentina	x	x	x	x	x	s	x
Armenia	x	x	x	x	x		x
Australia	x	x	x	x	x		x
Austria	x	x	x	x	x	x	x
Azerbaijan	x		x	x	x	s	x
Bahamas				x	x		x
Bahrain				x			x
Bangladesh	x		x	x	x	x	x
Barbados	x	x	x	x	x		x
Belarus	x	x	x	x	x		x
Belgium	x	x	x	x	x	s	x
Belize	x		s	s	x		x
Benin	x	x	x	s	x	s	x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Bhutan				s	x		x
Bolivia	x	x	x	x	x	x	x
Bosnia and Herzegovina	x	x	x	x	x	s	x
Botswana	x			x	x		x
Brazil	x		x	x	x		x
Brunei Darussalam							x
Bulgaria	x	x	x	x	x	s	x
Burkina Faso	x	x	x	x	x		x
Burundi	x		x	x	x		x
Cambodia	x		x	x	x		x
Cameroon	x	x	x	x	x		x
Canada	x	x	x	x	x		x
Cape Verde	x		x	x	x		x
Central African Republic	x	x	x	x	x		x
Chad	x	x	x	x	x		x
Chile	x	x	x	x	x	s	x
China	s		s	x	x		x
Colombia	x	x	x	x	x	s	x
Comoros				s	x		x
Congo	x	x	x	x	x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Cook Islands							x
Costa Rica	x	x	x	x	x	s	x
Côte d'Ivoire	x	x	x	x	x		x
Croatia	x	x	x	x	x	s	x
Cuba				x	x	s	x
Cyprus	x	x	x	x	x		x
Czech Rep	x	x	x	x	x	s	x
Democratic People's Republic of Korea	x		x				x
Democratic Republic of the Congo	x	x	x	x	x		x
Denmark	x	x	x	x	x	x	x
Djibouti					x		x
Dominica	x		x		x		x
Dominican Republic	x	x	x	x	x	s	x
Ecuador	x	x	x	x	x	s	x
Egypt	x		x	x	x		x
El Salvador	x	x	x	x	x		x
Equatorial Guinea	x	x	x		x		x
Eritrea					x		x
Estonia	x	x	x	x	x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Ethiopia	x		x	x	x		x
Fiji				x	x		x
Finland	x	x	x	x	x	s	x
Former Yugoslav Rep of Macedonia	x	x	x	x	x	s	x
France	x	x	x	x	x	x	x
Gabon	x		x	x	x		x
Gambia	x	x	x	x	x		x
Georgia	x	x	x	x	x		x
Germany	x	x	x	x	x	s	x
Ghana	x	x	x	x	x	s	x
Greece	x	x	x	x	x	s	x
Grenada	x		x	s	x		x
Guatemala	x		x	x	x	s	x
Guinea	x	x	x	x	x		x
Guinea Bissau	s	s	x	s	x	s	x
Guyana	x	x	x	x	x		x
Haiti	x			x	x		x
Holy See				x			x
Honduras	x	s	x		x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Hungary	x	x	x	x	x		x
Iceland	x	x	x	x	x	s	x
India	x		x	x	x		x
Indonesia				x	x	s	x
Iran (Islamic Rep of)	x		x	x			x
Iraq	x		x	x	x		x
Ireland	x	x	s	s	x	x	x
Israel	x		x	x	x		x
Italy	x	x	x	x	x	x	x
Jamaica	x	x	x	x	x		x
Japan	x		x	x	x		x
Jordan	x		x	x	x		x
Kazakhstan				x	x	s	x
Kenya	x		x		x		x
Kiribati							x
Kuwait	x		x	x	x		x
Kyrgyzstan	x	x	x	x	x		x
Lao People's Dem Republic				x	x		x
Latvia	x	x	x	x	x		x
Lebanon	x		x	x	x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Lesotho	x	x	x	x	x	s	x
Liberia	s		s	x	x		x
Libyan Arab Jamahiriya	x	x	x	x	x		x
Liechtenstein	x	x	x	x	x	s	x
Lithuania	x	x	x	x	x	s	x
Luxembourg	x	x	x	x	x	s	x
Madagascar	x	x	x	x	x	s	x
Malawi	x	x	x	x	x	s	x
Malaysia					x		x
Maldives				x	x		x
Mali	x		x	x	x		x
Malta	x	x	x	x	x		x
Marshall Islands							x
Mauritania				x			x
Mauritius	x	x	x	x	x		x
Mexico	x		x	x	x	s	x
Micronesia (Fed States of)							x
Monaco	x		x	x			x
Mongolia	x	x	x	x	x	s	x
Morocco	x		x	x	x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Mozambique	x			x	x		x
Myanmar					x		x
Namibia	x	x	x	x	x	x	x
Nauru							x
Nepal	x	x	x	x	x		x
Netherlands	x	x	x	x	x	s	x
New Zealand	x	x	x	x	x	x	x
Nicaragua	x	x	x	x	x		x
Niger	x	x	x	x	x		x
Nigeria	x		x	x	x	s	x
Niue							x
Norway	x	x	x	x	x	s	x
Oman							x
Pakistan				x	x		x
Palau							x
Panama	x	x	x	x	x	s	x
Papua New Guinea				x	x		x
Paraguay	x	x	x	s	x	s	x
Peru	x	x	x	x	x		x
Philippines	x	x	x	x	x	s	x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Poland	x	x	x	x	x		x
Portugal	x	x	x	x	x	s	x
Qatar				x			x
Republic of Korea	x	x	x	x	x		x
Republic of Moldova	x		x	x	x		x
Romania	x	x	x	x	x	s	x
Russian Federation	x	x	x	x	x		x
Rwanda	x		x	x	x		x
Saint Kitts and Nevis					x		x
Saint Lucia				x	x		x
St Vincent and the Grenadines	x	x	x	x	x		x
Samoa					x		x
San Marino	x	x	x				x
Sao Tome and Principe	s	s	s	s	s	s	x
Saudi Arabia				x	x		x
Senegal	x	x	x	x	x	x	x
Seychelles	x	x	x	x	x		x
Sierra Leone	x	x	x	x	x	s	x
Singapore					x		x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Slovakia	x	x	x	x	x	x	x
Slovenia	x	x	x	x	x	s	x
Solomon Islands			x	x			x
Somalia	x	x	x	x			
South Africa	x		x	x	x		x
Spain	x	x	x	x	x	s	x
Sri Lanka	x	x	x	x	x		x
Sudan	x		x	x			x
Suriname	x	x	x	x	x		x
Swaziland				x			x
Sweden	x	x	x	x	x	s	x
Switzerland	x		x	x	x		x
Syrian Arab Republic	x		x	x			x
Tajikistan	x	x	x	x	x	s	x
Thailand	x		x		x	x	x
Togo	x	x	x	x	x		x
Tonga				x			x
Trinidad and Tobago	x	x	x	x	x		x
Tunisia	x		x	x	x		x
Turkey	s		s	s	x	s	x

	International Covenant on Civil and Political Rights (the Political Covenant)	Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR Optional Protocol)	International Covenant on Economic, Social and Cultural Rights (the Economic Covenant)	International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Convention)	Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention)	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Optional Protocol)	Convention on the Rights of the Child (the Children's Convention)
Turkmenistan	x	x	x	x	x		x
Tuvalu					x		x
Uganda	x	x	x	x	x		x
Ukraine	x	x	x	x	x	s	x
United Arab Emirates				x			x
United Kingdom	x		x	x	x		x
United Rep of Tanzania	x		x	x	x		x
United States of America	x		s	x	s		s
Uruguay	x	x	x	x	x	s	x
Uzbekistan	x	x	x	x	x		x
Vanuatu					x		x
Venezuela	x	x	x	x	x	s	x
Viet Nam	x		x	x	x		x
Yemen	x		x	x	x		x
Yugoslavia	x	x	x	x	x		x
Zambia	x	x	x	x	x		x
Zimbabwe	x		x	x	x		x

European Convention and Social Charter

To check the current ratification status of European human rights documents, see: conventions.coe.int/treaty/EN/cadreprincipal.htm

	European Convention on Human Rights (the European Convention)	European Social Charter	European Social Charter (Revised)
Albania	x		s
Andorra	x		s
Austria	x	x	s
Belgium	x	x	s
Bulgaria	x		x
Croatia	x	s	
Cyprus	x	x	x
Czech Republic	x	x	s
Denmark	x	x	s
Estonia	x		x
Finland	x	x	s
France	x	x	x
Georgia	x		s
Germany	x	x	
Greece	x	x	s
Hungary	x	x	
Iceland	x	x	s
Ireland	x	x	x
Italy	x	x	x
Latvia	x	s	
Liechtenstein	x	s	
Lithuania	x		s
Luxembourg	x	x	s
Malta	x	x	
Moldova	x		s
Netherlands	x	x	
Norway	x	x	
Poland	x	x	
Portugal	x	x	s
Romania	x	s	x

	European Convention on Human Rights (the European Convention)	European Social Charter	European Social Charter (Revised)
Russia	x		s
San Marino	x		
Slovakia	x	x	s
Slovenia	x	s	x
Spain	x	x	s
Sweden	x	x	x
Switzerland	x	s	
The Former Yugoslav Republic of Macedonia	x	s	
Turkey	x	x	
Ukraine	x	s	s
United Kingdom	x	x	s

Inter-American Treaties

To check the current ratification of Inter-American human rights conventions, see: www.cidh.oas.org/basic.htm.

	American Convention on Human Rights "Pact of San Jose, Costa Rica" (the American Convention)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" (the Protocol to the American Convention)	Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (the Inter-American Convention)
Antigua and Barbuda			x
Argentina	x	s	x
Bahamas			x
Barbados	x		x
Belize			x
Bolivia	x	s	x
Brazil	x	x	x
Canada			
Chile	x		x
Colombia	x	x	
Costa Rica	x	x	x
Cuba			

	American Convention on Human Rights "Pact of San Jose, Costa Rica" (the American Convention)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" (the Protocol to the American Convention)	Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (the Inter-American Convention)
Dominica	x		x
Dominican Republic	x	s	x
Ecuador	x	x	x
El Salvador	x	x	x
Grenada	x		
Guatemala	x	s	x
Guyana			x
Haiti	x	s	x
Honduras	x		x
Jamaica	x		
Mexico	x	x	x
Nicaragua	x	s	x
Panama	x	x	x
Paraguay	x	x	x
Peru	x	x	x
Saint Kitts and Nevis			x
Saint Lucia			x
Saint Vincent and the Grenadines			x
Suriname	x	x	
Trinidad and Tobago	x		x
United States	s		
Uruguay	x	x	x
Venezuela	x	s	x

African Charter

From H. Hannum, ed., Guide to International Human Rights Practice, 3rd ed., Transnational Publishers, Inc. and The Procedural Aspects of International Law Institute, 1999.

	African Charter on Human and Peoples' Rights (the African Charter)
Algeria	x
Angola	x
Benin	x
Botswana	x
Burkina Faso	x
Burundi	x
Cameroon	x
Cape Verde	x
Central African Republic	x
Chad	x
Comoros	x
Congo	x
Côte d'Ivoire	x
Democratic Republic of Congo	x
Djibouti	x
Egypt	x
Equatorial Guinea	x
Ethiopia	x
Gabon	x
Gambia	x
Ghana	x
Guinea	x
Guinea-Bissau	x
Kenya	x
Lesotho	x
Liberia	x
Libya	x
Madagascar	x

	African Charter on Human and Peoples' Rights (the African Charter)
Malawi	x
Mali	x
Mauritania	x
Mauritius	x
Mozambique	x
Namibia	x
Niger	x
Nigeria	x
Rwanda	x
Sahrawi Arab Democratic Republic	x
Sao Tome and Principe	x
Senegal	x
Seychelles	x
Sierra Leone	x
Somalia	x
South Africa	x
Sudan	x
Swaziland	x
Tanzania	x
Togo	x
Tunisia	x
Uganda	x
Zambia	x
Zimbabwe	x

Appendix 4

Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and health (Article 12)

CEDAW, *General Recommendation 24*, UN GAOR, 1999, UN Doc. A/54/38/ Rev.1, pp.3-7.

Introduction

1. The Committee on the Elimination of Discrimination against Women, affirming that access to health care, including reproductive health is a basic right under the Convention on the Elimination of Discrimination against Women, determined at its 20th session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention.

Background

2. States parties' compliance with article 12 of the Convention is central to the health and well-being of women. It requires States to eliminate discrimination against women in their access to health care services, throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period. The examination of reports submitted by States parties pursuant to article 18 of the Convention demonstrates that women's health is an issue that is recognized as a central concern in promoting the health and well-being of women. For the benefit of States parties and those who have a particular interest in and concern with the issues surrounding women's health, the present general recommendation seeks to elaborate the Committee's understanding of article 12 and to address measures to eliminate discrimination in order to realize the right of women to the highest attainable standard of health.

3. Recent United Nations world conferences have also considered these objectives. In preparing this general recommendation, the Committee has taken into account relevant programmes of action adopted at United Nations world conferences and, in particular, those of the 1993 World Conference on Human Rights, the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. The Committee has also noted the work of the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and other United Nations bodies. It has also collaborated with a large number of non-governmental organizations with a special expertise in women's health in preparing this general recommendation.

4. The Committee notes the emphasis which other United Nations instruments place on the right to health and to the conditions which enable good health to be achieved. Among such instruments are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

5. The Committee refers also to its earlier general recommendations on female circumcision, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), disabled women, violence against women and equality in family relations, all of which refer to issues which are integral to full compliance with article 12 of the Convention.

6. While biological differences between women and men may lead to differences in health status, there are societal factors which are determinative of the health status of women and men and which can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

7. The Committee notes that the full realization of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their life span by means of a food supply that is safe, nutritious and adapted to local conditions. Towards this end, States parties should take steps to facilitate physical and economic access to productive resources especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.

Article 12

8. Article 12 reads as follows:

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

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

States parties are encouraged to address the issue of women's health throughout the woman's lifespan. For the purposes of this general recommendation, therefore, women includes girls and adolescents. This general recommendation will set out the Committee's analysis of the key elements of article 12.

Key elements

Article 12 (1)

9. States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.

10. States parties are encouraged to include in their reports information on diseases, health conditions and conditions hazardous to health that affect women or certain groups of women differently from men, as well as information on possible intervention in this regard.

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

12. States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors which differ for women in comparison to men, such as:

(a) Biological factors which differ for women in comparison with men, such as their menstrual cycle and their reproductive function and menopause. Another example is the higher risk of exposure to sexually transmitted diseases which women face;

(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, unequal power relationships between women and men in the home and workplace may negatively affect women's

nutrition and health. They may also be exposed to different forms of violence which can affect their health. Girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;

(c) Psychosocial factors which vary between women and men include depression in general and post-partum depression in particular as well as other psychological conditions, such as those that lead to eating disorders such as anorexia and bulimia;

(d) While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.

13. The duty of States parties to ensure, on a basis of equality between men and women, access to health care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system which ensures effective judicial action. Failure to do so will constitute a violation of article 12.

14. The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care. For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried[1] or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.

15. The obligation to protect rights relating to women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based violence is a critical health issue for women, States parties should ensure:

(a) The enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address violence against women and abuse of girl children and the provision of appropriate health services;
(b) Gender-sensitive training to enable health care workers to detect and

manage the healthconsequences of gender-based violence;

(c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health care professionals guilty of sexual abuse of women patients;

(d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

16. States parties should ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees.

17. The duty to fulfil rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care. The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as tuberculosis and HIV/AIDS. The Committee is concerned at the growing evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties, to protect their health and the measures they have taken to ensure the provision of such services.

18. The issues of HIV/AIDS and other sexually transmitted disease are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice and discrimination, the right to sexual health information, education and services for

all women and girls, including those who have been trafficked, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality.

19. In their reports States parties should identify the test by which they assess whether women have access to health care on a basis of equality of men and women in order to demonstrate compliance with article 12. In applying these tests, States parties should bear in mind the provisions of article 1 of the Convention. Reports should therefore include comments on the impact that health policies, procedures, laws and protocols have on women when compared with men.

20. Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

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

22. States parties should also report on measures taken to ensure access to quality health care services, for example, by making them acceptable to women. Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

23. In their reports, States parties should state what measures they have taken to ensure timely access to the range of services which are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counseling on all methods of family planning.[2]

24. The Committee is concerned about the conditions of health care services for older women, not only because women often live linger than men and are more likely than men to suffer from disabling and degenerative chronic diseases, such

as osteoporosis and dementia, but because they often have the responsibility for their aging spouses. Therefore, States parties should take appropriate measures to ensure the access of older women to health services that address the handicaps and disabilities associated with aging.

25. Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.

Article 12 (2)

26. Reports should also include what measures States parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period. Information on the rates at which these measures have reduced maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included.[3]

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

Other relevant articles in the Convention

28. When reporting on measures taken to comply with article 12, States parties are urged to recognize its interconnection with other articles in the Convention that have a bearing on women's health. Those articles include article 5 (b), which requires States parties to ensure that family education includes a proper understanding of maternity as a social function; article 10, which requires States parties to ensure equal access to education, thus enabling women to access health care more readily and reducing female students' drop-out rates, which are often due to premature pregnancy; article 10(h) which provides that States parties provide to women and girls specific educational information to help ensure the well-being of families, including information and advice on family planning; article 11, which is concerned, in part, with the protection of women's health and safety in working conditions, including the safeguarding of the

reproductive function, special protection from harmful types of work during pregnancy and with the provision of paid maternity leave; article 14 (2) (b), which requires States parties to ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning, and (h), which obliges States parties to take all appropriate measures to ensure adequate living conditions, particularly housing, sanitation, electricity and water supply, transport and communications, all of which are critical for the prevention of disease and the promotion of good health care; and article 16 (1) (e), which requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights. Article 16 (2) also proscribes the betrothal and marriage of children, an important factor in preventing the physical and emotional harm which arise from early childbirth.

Recommendations for government action

29. States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

30. States parties should allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs.

31. States parties should also, in particular:

(a) Place a gender perspective at the centre of all policies and programmes affecting women's s health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women;

(b) Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;

(c) Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion;

(d) Monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care;

(e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;

(f) Ensure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

Notes

[1] General Recommendation 21, paragraph 29.

[2] Health education for adolescents should further address, inter alia, gender equality, violence, prevention of sexually transmitted diseases and reproductive and sexual health rights.

[3] Reference to resolutions in which the Committee adopted the Cairo and Beijing recommendations to reduce maternal mortality and morbidity

Appendix 5

Select Bibliography and Listing of Relevant Websites

This list of resources, although not exhaustive, is intended as a guide to additional useful information about the topics discussed in Chapters II through IV of this manual. Please note that internet links change and develop constantly. (Those included below are functional as of December 2000.)

Chapter II: Understanding Unsafe Motherhood

H.K. Atrash, S. Alexander, C.J. Berg, "Maternal Mortality in Developed Countries: Not Just a Concern of the Past," Obstetrics and Gynecology, 1995, 86: 700-5.

C. AbouZahr, "Maternal Mortality Overview," in: C. Murray, A. Lopez, eds., Health Dimensions of Sex and Reproduction, Boston: Harvard School of Public Health on Behalf of the World Health Organization and the World Bank, 111-164, 1998.

C. AbouZahr, "Measuring maternal mortality: What do we need to know?" in: M. Berer, T.K.S. Ravindran, eds., Safe Motherhood Initiatives: Critical Issues, Special Edition, Reproductive Health Matters, 13-26, 1999.

M. Berer, T.K.S. Ravindran, eds., Safe Motherhood Initiatives: Critical Issues, Special Edition, Reproductive Health Matters, 1999.

S.J. Jejeebhoy, The Importance of Social Science Research in the Promotion of Sexual and Reproductive Choice of Adolescents. Medicine and Law, 1999, 18:255-275.

D. Maine et al., Guidelines for Monitoring the Availability and Use of Obstetric Services, 2nd ed., New York: UNICEF, 1997.

D. Maine et al., The Design and Evaluation of Maternal Mortality Programs, Center for Population and Family Health, School of Public Health, Columbia University, 1997.

A. Starrs, The Safe Motherhood Action Agenda: Priorities for the Next Decade, Report on the Safe Motherhood Technical Consultation, 18-23 October 1997, Colombo, Sri Lanka, New York: Family Care International, 1998.

UNICEF. Programming for Safe Motherhood: Guidelines for Maternal and Neonatal Survival. New York: UNICEF, 1999.

World Health Organization, Mother-Baby Package: Implementing Safe Motherhood in Countries, Geneva: World Health Organization, 1994.

World Health Organization, Safe Motherhood: A Newsletter of Worldwide Activity, Geneva: World Health Organization.

The Alan Guttmacher Institute

www.agi-usa.org/home.html

AGI is an independent non-profit corporation and is a special affiliate of PPFA. The site contains information on reproductive health issues, such as sexual behaviour, pregnancy and birth, prevention and contraception, abortion, sexually transmitted diseases, youth, law and policy.

Family Care International

www.familycareintl.org

Family Care International (FCI) was established as a non-profit organization dedicated to improving women's sexual and reproductive health and rights, with a special emphasis on making pregnancy and childbirth safer. FCI's special priority is to develop resource materials and provide assistance to these developing country partners that want to design community-level programs based on women's needs and realities. The Organization has offices in the United States, Africa, Mexico and Bolivia. This site contains information about initiatives in different regions of the world as well as materials that can be ordered through the organization. The site is available in English or French.

The Global Reproductive Health Forum

www.hsph.harvard.edu/organizations/healthnet

Global Reproductive Health Forum at Harvard aims to encourage the proliferation of critical, democratic discussion about reproductive health rights and gender on the net with a special focus on South Asia and West Africa. It gives databases as well as research papers on maternal health.

The International Federation of Gynecology and Obstetrics

www.figo.org

This site contains information on the Save the Mothers Fund – a FIGO project established in 1997 over a 3-year period to expand its activities in the area of safe motherhood. The aim is to mobilize the obstetric and gynecological community in developed and developing countries to work in partnership to demonstrate the most cost-effective way to save mothers' lives.

The Population Council – Reproductive Health and Family Planning

www.popcouncil.org/rhfp/safemom.html

The Population Council has participated in efforts to reduce maternal mortality since the early 1980s. The Council's research agenda has sought to improve obstetric, postpartum, and family planning services, including the prevention of unsafe abortions, in developing countries.

Safe Motherhood

www.safemotherhood.org

In 1987 a coalition of the world's leaders in maternal and child health, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Bank, the International Planned Parenthood Federation (IPPF), and the Population Council, joined forces and developed the Inter-Agency Group for Safe Motherhood to assess the problem of maternal deaths and disability and to recommend solutions. This site contains information about such initiatives. The fact sheets provide a useful overview. The site is available in English and French.

The United Nations Children's Fund

www.unicef.org/safe

This site provides useful information on steps which may be taken to help build mother-friendly societies.

World Bank – Safe Motherhood

www.worldbank.org/html/extdr/hnp/population

This site offers a variety of information sources on the World Bank's efforts to improve maternal health around the world.

World Health Organization, Department of Reproductive Health and Research

www.who.int/reproductive-health

The Department of Reproductive Health and Research (including the Special Programme of Research, Development and Research Training in Human Reproduction) forms part of the Family and Community Health activities of the World Health Organization and combines research with country support work.

Chapter III: Human Rights Affecting Safe Motherhood

G. Alfredsson, K. Tomasevski, eds., A Thematic Guide to Documents on Health and Human Rights, The Hague: Martinus Nijhoff Publishers, 1998.

I. Boerefijn and B. Toebes, Health and Human Rights, Health Issues discussed by the United Nations Treaty Monitoring Bodies, Netherlands Institute for Human Rights, SIM Special Issue 21, 1998, 25-53.

I. Brownlie, ed., Basic Instruments on Human Rights, 4th ed., Oxford: Clarendon Press, 1995.

S. Coliver, ed., The Right to Know: Human Rights and Access to Reproductive Health Information, London, U.K.: Article 19, and Philadelphia: University of Pennsylvania Press, 1995.

R.J. Cook and B.M. Dickens, Considerations for Formulating Reproductive Health Laws, 2nd ed. Geneva: World Health Organization, 2000.

R.J. Cook, "Human Rights Law and Safe Motherhood," European J. of Health Law, 5: 357-375, 1998.

M.K. Eriksson, The Right to Marry and To Found a Family, Uppsala, Iustus Forlag, 1990.

International Planned Parenthood Federation, Charter on Sexual and Reproductive Rights, London: IPPF, 1996.

A. McChesney, Promoting and Defending Economic, Social and Cultural Rights: A Handbook. Washington, D.C.: American Association for the Advancement of Science, 2000.

K. McDonald, J. Stanchieri, I. Merali and R.J. Cook, The Application of Human Rights to Reproductive and Sexual Health: A Compilation of The Work of UN Treaty Bodies, International Programme on Reproductive and Sexual Health Law, Toronto, Faculty of Law, University of Toronto & Ottawa, Action Canada for Population and Development (forthcoming 2001).

M. O'Flaherty, Human Rights and the UN: Practice before the Treaty Bodies. London: Sweet & Maxwell, 1996

C.A.A. Packer, “Preventing Adolescent Pregnancy: The Protection Offered by International Human Rights Law,” Int’l J. of Children’s Rights, 5: 46-76, 1997.

B.C.A. Toebes, The Right to Health as a Human Right in International Law.Antwerpen: Intersentia-Hart, 1999.

United Nations, Manual on Human Rights Reporting, New York: United Nations, 1997.

World Health Organization (Division of Reproductive Health), Monitoring Reproductive Health: Selecting a Short List of National and Global Indicators, WHO/RHT/HRP/97.26, Geneva: World Health Organization, 1997.

A.E. Yamin, D. Maine, “Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations,” Human Rights Quarterly, 21: 563-607, 1999.

Human Rights Treaties

International

Universal Declaration of Human Rights, 10 December 1948, G.A. Res. 217A (III), U.N. Doc. A/810, at 71.

www.un.org/Overview/rights.html

International Covenant on Civil and Political Rights (ICCPR), 16 December 1966, 999 U.N.T.S. 171, entered into force 23 March 1976.

Text: www1.umn.edu/humanrts/instree/b3ccpr.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

Optional Protocol to the International Covenant on Civil and Political Rights, 16 December 1966, 999 U.N.T.S. 302, entered into force 23 March 1976.

Text: www1.umn.edu/humanrts/instree/b4ccprp1.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

International Covenant on Economic, Social and Cultural Rights (ICESCR), 16 December 1966, 993 U.N.T.S. 3, entered into force 3 Jan. 1976.

Text: www.unhchr.ch/html/menu3/b/a_cescr.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 18 December 1979, G.A. Res.34/180, UN GAOR, 34th Sess., Supp. No. 46 at 193, UN Doc. A/34/46, entered into force 3 September 1981.

Text: www1.umn.edu/humanrts/instree/e1cedaw.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women

Text: www.un.org/womenwatch/daw/cedaw/protocol/current.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

International Convention for the Elimination of All Forms of Racial Discrimination (CERD), 21 December 1965, 660 U.N.T.S. 195, entered into force 4 January 1969.

Text: www1.umn.edu/humanrts/instree/d1cerd.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

The Convention on the Rights of the Child (CRC), 20 November 1989, G.A. Res. 44/25 (XLIV), UN GAOR, 44th Sess., Supp. No. 49 at 167, UN Doc. A/44/49, entered into force 2 September 1990.

Text: www1.umn.edu/humanrts/instree/k2crc.htm

Ratifications: www.unhchr.ch/tbs/doc.nsf

UN Conferences

International Conference on Population and Development (ICPD), Cairo, Egypt, 13-15 September 1994, UN Document A/Conf. 171/13.

See: www.iisd.ca/linkages/cairo.html

General Assembly Special Session on the International Conference on Population and Development (ICPD + 5), General Assembly A/Res/S-21/2, 8 Nov 1999.

See: www.unfpa.org/ICPD/icpdmain.htm

The Fourth World Conference on Women, Beijing, China, 4-15 September 1995, UN Document A/CONF.177/20.

See: www.un.org/womenwatch/daw/beijing/platform/

Regional

African [Banjul] Charter on Human and Peoples' Rights, 27 June 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986.

Text: www1.umn.edu/humanrts/instree/z1afchar.htm

Ratifications: www1.umn.edu/humanrts/instree/ratz1afchar.htm (as of 1 Aug 1994)

African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

Text: www1.umn.edu/humanrts/africa/afchild.htm

European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) 4 November 1940, E.T.S. No. 5; 213 U.N.T.S. 222, entered into force 3 September 1953; as amended by Protocol Nos. 3, 5 and 8 which entered into force on 21 September 1970, 20 December 1971 and 1 January 1990, respectively.

Text and Ratifications: conventions.coe.int/treaty/EN/cadreprincipal.htm

European Social Charter, 13 October 1961, 529 U.N.T.S. 89, entered into force 26 February 1965.

European Social Charter, Revised (1996) E.T.S. No. 163, in force, 1999.

Text and Ratifications: conventions.coe.int/treaty/EN/cadreprincipal.htm

Inter-American System

For texts and ratification information of the following, see:

www.cidh.oas.org/basic.htm

American Declaration of the Rights and Duties of Man

American Convention on Human Rights “Pact of San Jose, Costa Rica”

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights “Protocol of San Salvador”

Inter-American Convention to Prevent and Punish Torture

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women “Convention of Belem Do Pará”

Statute of the Inter-American Commission on Human Rights

Regulations of the Inter-American Commission on Human Rights

Statute of the Inter-American Court on Human Rights

Academic and NGO Sites

The Annual Review of Population Law, Harvard Law Library

www.law.harvard.edu/Programs/annual_review/

This site contains excerpts of recent legislation, constitutions and court decisions on reproductive and maternal health from every country in the world. It also offers recent developments in national legal systems and a searchable database.

The Center for Reproductive Law and Policy

www.crlp.org

The Center for Reproductive Law and Policy is "a non-profit legal and policy advocacy organization dedicated to promoting women's reproductive rights". This excellent site contains information on CRLP projects pertaining to maternal health in the United States and worldwide. It also provides online access to newsletters and some publications of the CRLP.

Commonwealth Medical Association Trust (ComMAT)

http://www.commat.org

This site contains an overview of upcoming sessions of the five UN Treaty Bodies discussed in this manual. It also provides the schedules for States Parties' reports to the human rights treaty bodies. In addition, ComMAT posts the portions of States Parties' reports that pertain to health.

Human Rights Internet

www.hri.ca

This is a site dedicated to international NGOs, with a database of human rights websites, including those pertaining to maternal health, a documentation centre and publishing house. It also provides a world calendar of human rights events occurring each month around the globe on which visitors can post information on events in their regions.

Human Rights Watch

www.hrw.org

This site provides a list of publications, current events and the Human Rights Watch World Report, focused on protecting the human rights of people around the world by bringing offenders to justice, preventing discrimination, upholding political freedom and protecting people from inhuman conduct. A section on Women's Rights includes information pertaining to maternal health and rights.

International Women's Rights Action Watch (IWRAW)

www.igc.org/iwraw/

This site offers access to an online newsletter, a publications list and updates on the work of the United Nations CEDAW (Women's Convention) Committee, which reviews country reports that focus on the advancement of women's human rights and maternal health.

Women's Human Rights Resources: Maternal Health

www.law-lib.utoronto.ca/Diana/repro/maternal.htm

The Women's Human Rights Resources web site is a project of the Bora Laskin Law Library at the University of Toronto, Faculty of Law. The site is produced by the Women's Human Rights Resources group in consultation and collaboration with law librarians, lawyers, students, researchers, activists and human rights experts around the world. The section on Maternal Health contains articles, documents and links to other resources on this subject.

Chapter 4: Strategies for Implementation

A. Ahmed An-Na'im, ed., Universal Rights, Local Remedies: Implementing Human Rights in the Legal Systems of Africa. London: Interights, 1999.

A.P. Blaustein, G.H. Flanz, Constitutions of the Countries of the World, Dobbs Ferry, New York: Oceana Publications, 1999.

T. Buergenthal, International Human Rights in a Nutshell, St. Paul, Minnesota: West Publishing Co., 1988.

A. Byrnes, J. Connors, L. Bik, eds., "Advancing the Human Rights of Women: Using International Human Rights Standards in Domestic Litigation," Papers and statements from the Asia/South Pacific Regional Judicial Colloquium, Hong Kong, 20-22 May 1996, London: The Commonwealth Secretariat, 1997.

R. Fisher, W. Ury, B. Patton, Getting to YES, 2nd ed., New York: Penguin Books, 1991.

H. Hannum, ed., Guide to International Human Rights Practice, 3rd ed., Transnational Publishers, Inc. and The Procedural Aspects of International Law Institute, 1999.

C.E. Lockwood, D.B. Magraw, M.F. Spring, S.I. Strong, eds., The International Human Rights of Women: Instruments of Change, American Bar Association Section of International Law and Practice, 1998.

J. Mertus, N. Flowers, M. Dutt, Local Action Global Change: Learning About the Human Rights of Women and Girls, UNIFEM and The Center for Women's Global Leadership, 1999.

M.A. Schuler, D.Q. Thomas, eds., Women's Human Rights Step by Step, Washington: Women, Law and Development International and Human Rights Watch Women's Rights Project, 1999.

D. Shelton, "The Promise of Regional Human Rights Systems," In: B.H. Weston, S.P. Marks, eds. & contribs., The Future of International Human Rights, New York: Transnational Publishers, Inc., 1999.

The Constitution Finder

www.urich.edu/~jpjones/confinder/

This index offers constitutions, charters, amendments and other related documents. Nations of the world are listed alphabetically, and each is linked to its constitutional text posted somewhere on the internet.

The United Nations Center for Human Rights

www3.itu.int/MISSIONS/US/bb/hrights.html

This site provides information on the UN Center in Geneva, the High Commissioner for Human Rights, the UN Commission on Human Rights, the Subcommission on Human Rights and Treaty Monitoring Bodies.

The United Nations High Commissioner for Human Rights

www.unhchr.ch

This site offers image and text versions of the organizational structure for the United Nations system in the field of human rights. From this site, one can access the United Nations Treaty Bodies State Party Reports and Concluding Observations for the following: the Economic Covenant, the Political Covenant, the Women's Convention, the Race Conventions and the Children's Convention, among others. "Status of Ratification" information is also listed by country and by treaty.

Human Rights Committee

www.unhchr.ch/html/menu2/6/hrc.htm

Committee on Economic, Social and Cultural Rights

www.unhchr.ch/html/menu2/6/cescr.htm

Committee on the Elimination of All Forms of Discrimination against Women

www.un.org/womenwatch/daw/cedaw/

Committee on the Elimination of All Forms of Racial Discrimination
www.unhchr.ch/html/menu2/6/cerd.htm

Committee on the Rights of the Child
www.unhchr.ch/html/menu2/6/crc.htm

European Court of Human Rights
www.echr.coe.int

Inter-American Commission on Human Rights
www.cidh.oas.org

Inter-American Court of Human Rights
//corteidh-oea.nu.or.cr/ci (Spanish)
//corteidh-oea.nu.or.cr/ci/HOME_ING.HTM (English)

African Commission on Human and Peoples' Rights
www.oau-oua.org

Appendix 6

Table of Cases

Aumeeruddy-Cziffra et al. v. *Mauritius*, Comm. No. 35/1978, UN Doc. A/36/40 (1981).

(The Human Rights Committee required that Mauritius change its laws to ensure women the same rights to family life as men enjoy (Art. 17, the Political Covenant).)

Broeks v. *The Netherlands*, Comm. No. 172/1984, 42 UN GAOR Supp. No. 40at p.139, UN Doc. A/42/40 (1987).

(The Human Rights Committee required that the Netherlands provide women with the same entitlements to social security benefits as men enjoy (Art. 2, the Political Covenant).)

Case 7615 (Brazil) (1985), Inter-Am. Comm. H.R. Res. No. 12/85, Annual Report of the Inter-American Commission on Human Rights, 1984-85.

(The Commission held that by failing to take timely and effective health measures on behalf of the Yanomami Indians, the Brazilian government violated its obligations under the American Declaration to preserve health (Art. XI, American Declaration of the Rights and Duties of Man).)

Cruz Bermudez, et al. v. *Ministerio de Sanidad y Asistencia Social (MSAS)*, Case No. 15789.

(The Venezuelan Supreme Court required, according to the rights to life and health, that the Ministry of Health provide the medicines prescribed to all HIV positive Venezuelans by government doctors, cover the cost of HIV blood tests in order for patients to obtain the necessary anti-retroviral treatments and treatments for opportunistic infections, develop the policies and programs necessary for affected patients' treatment and assistance, and make the reallocation of the budget necessary to carry out the decision of the Court (Arts. 58, 76, the 1961 Venezuelan Constitution).)

D. v. United Kingdom (1997), Eur. Ct. H.R., 24 E.H.R.R. 423.

(The European Court held that the deportation of a convicted drug trafficker who was at a very advanced stage of terminal and incurable AIDS to his country where he would have no hope of receiving appropriate treatment nor where he had any family would constitute inhuman treatment (Art. 3, the European Convention).)

Feldbrugge v. *The Netherlands* (1985), Eur. Ct. H.R. Ser. A, No. 99, 8 E.H.R.R. 149.

(The European Court held that the right to a fair hearing was violated by proceedings that barred the applicant from continuing to receive a health insurance allowance (Art. 6, the European Convention).)

Judgement of Jan. 15, 1975, Conseil Constitutionnel, 1975 Recueil Dalloz-Sirey [D.S. Jur.] 529, Journal Officiel, Jan. 16, 1975 (France).

(The Court held that France's liberal abortion law, which permits therapeutic abortion in broadly defined terms, including a woman's distress, was consistent with the principle of liberty stated in Art. 2 of the Declaration of the Rights of Man and of the Citizen.)

Judgement No.108/81 of June 25, 1981, Corte Costituzionale, 57 Raccolta Ufficiale della Corte Costituzionale [Rac. uff. corte cost.] 823, 1981 (Italy).

(The Court upheld legislation, protective of women's health interests under various articles, including one protecting human life (Art. 2, Italian Constitution).)

Juristenvereiniging Pro Vita v. *De Staat der Nederlanden (Ministerie van Welzijn, Volksgezondheid en Cultuur*) [1990] NJ 2986 (Hof, The Hague, 8 February 1990).

(The Court held that there was no conflict between the Termination of Pregnancy Act and the guarantee of protection of the right to life contained in Art. 2 of the European Convention.)

Kjeldsen v. *Denmark* (1976), Eur. Ct. H.R. Ser. A, No. 23, 1 E.H.R.R. 711.

(The Court upheld compulsory sex education in State schools as it was conveyed in an objective, critical and pluralistic manner that did not constitute indoctrination or disrespect for parents' religious or philosophical views (Art. 2 of Protocol No. 1, the European Convention).)

Mohini Jain v. *State of Karnataka*, A.I.R. 1992 S.C. 1858; (1992) 3 S.C.C. 666.

(The Court held that the Indian Constitution requires that "the State shall promote with special care the educational and economic interests of the weaker sections of the people…and shall protect them from social injustice and all forms of exploitation." (Arts. 41, 45, 46 Indian Constitution).)

Open Door Counselling and Dublin Well Women v. *Ireland* (1992), Eur. Ct. H.R. Ser. A, No. 246, 15 E.H.R.R. 244.

(The European Court held that a governmental ban on counselling and circulation of information regarding where to find legal abortions in Britain violated the right to impart and receive information (Art. 10, the European Convention)).

Paschim Banga Khet Mazdoor Samity v. *State of West Bengal* (1996) 4 SCC 37; (1996) 3 SCJ 25, digested in (1998) 2 Commonwealth Human Rights Law Digest 109.

(The Supreme Court of India held that the right to life was breached when various government hospitals denied a complainant emergency treatment for serious head injuries (Art. 21, Indian Constitution).)

Paton v. *United Kingdom* (1980), Eur. Comm. H.R., 3 E.H.R.R. 408.

(The Commission found that a husband's right to family life was not violated when he was not allowed to prevent his wife from having an abortion (Art. 8, the European Convention).)

R. v. *Birmingham City Council*, [1989] 2 W.L.R. 520 (H.L.) (U.K.), digested in (1989) 15 Commonwealth Law Bulletin 414.

(The Court held that the Birmingham local education authority was treating girls less favourably than boys, contrary to the Sex Discrimination Act 1975, because there were fewer places for girls than for boys in secondary schools (Section 1(1)(a)).)

R. v. *Morgentaler* (1988), 44 D.L.R. (4^{th}) 385 (S.C.C.) (Canada).

(The Court held that a restrictive criminal abortion provision violated a woman's right to security of the person (Section 7, Canadian Charter of Rights and Freedoms).)

Re Miriam Willingal (10 Feb 1997), MP No. 289 of 1996 (unreported), digested in (1998) 2 Commonwealth Human Rights Law Digest 57 (Papua New Guinea).

(It was held that a 'head pay' custom of including payment in the form of young women was an infringement of the woman's freedom to choose a husband of her wish from anywhere in Papua New Guinea (Section 32, Papua New Guinea Constitution).)

Soobramoney v. *the Minister of Health, Kwazulu Natal*, 1998 (1) SA 776 (Constitutional Court).

(The Court held that the state was not constitutionally required to provide long-term dialysis treatment for a claimant's chronic renal failure because rights, such as the right to health, are limited by reason of lack of resources; however, emergency services cannot be denied in situations where a person suffers a sudden catastrophe which calls for immediate medical attention (Section 27, South African Constitution).)

Tavares v. *France* (1991), Eur. Comm. H.R., Application No. 16593/90, (09/12/91 unpublished).

(The Commission held that this maternal death case was inadmissible for technical reasons, but it emphasized that the right to life not only requires states to take steps to prevent intentional killing but to take measures necessary to protect life against unintentional loss (Art. 2, the European Convention).)

Unni Krishnan v. *State of Andhra Pradesh*, A.I.R. 1993 S.C. 2178 at p. 2197.

(It was held that the 'right to education' is implicit in the right to life and personal liberty, but it is not an absolute right; after children reach the age of fourteen, their right to education is subject to the limits of economic capacity and development of the state (Arts. 21, 41, 45, 46, the Indian Constitution).)

Williams v. *Jamaica*, Comm. No. 609/1995, UN Doc. CCPR/C/61/D/609/1995 (17 Nov 1997).

(The Human Rights Committee held that denying a death row inmate adequate medical treatment for his mental condition was inhuman treatment as well as a denial of respect for the inherent dignity of his person (Arts. 7, 10(1), the Political Covenant).)

X. v. *United Kingdom* (1978), Eur. Comm. H.R. Application No. 7154, Decision 12 July 1978, European Commission of Human Rights, Decision & Reports 14: 31-35, June 1979.

(The Commission held that the government had taken appropriate and adequate measures to prevent death from vaccination but, had appropriate measures not been taken, the state would have been in breach of its duty to safeguard life (Art. 2, the European Convention).)

Appendix 7

Committee on Economic, Social and Cultural Rights, General Comment 14: The right to the highest attainable standard of health (Article 12)

CESCR, *General Comment 14*, UN Doc. E/C.12/2000/4, 11 August 2000.

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. (3)

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide

protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)

(b) *Accessibility.* Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

Article 12.2 (b). The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, *inter alia*, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services (15)

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at

community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

Gender perspective

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. (17)

    The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

II. STATES PARTIES' OBLIGATIONS

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. (21)

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all

alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. (24)

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical

equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

37. The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond

to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe

and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically

reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any

circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through *acts of commission* include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through *acts of omission* include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful

traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. (30) All victims of such violations should be entitled to adequate reparation,

which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided

by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Notes

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

2. In its resolution 1989/11.

3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

7. See paras. 18 and 19 of this General Comment.

8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to*: primary health care* typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; *secondary health care* is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; *tertiary health care* is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

11. *Prenatal* denotes existing or occurring before birth; *perinatal* refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); *neonatal*, by contrast, covers the period pertaining to the first four weeks after birth; while *post-natal* denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: "Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being", as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

14. ILO Convention No. 155, art. 4.2.

15. See para. 12 (b) and note 8 above.

16. For the core obligations, see paras. 43 and 44 of the present General Comments.

17. Article 24.1 of the Convention on the Rights of the Child.

18. See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, para. 43.

21. See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

24. General Assembly resolution 46/119 (1991).

25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

26. Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.

27. See para. 45 of this General Comment.

28. 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, chaps. VII and VIII.

29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, para. 9.

Appendix 8

Human Rights Committee, General Comment 28:
Equality of rights between men and women (Article 3)

HRC, *General Comment 28*, UN GAOR 2000, UN Doc. A/55/40, Annex VI, p. 133.

1. The Committee has decided to update its General Comment on Article 3 of this Covenant and to replace General Comment 4 (thirteenth session 1981), in the light of the experience it has gathered in its activities over the last 20 years. This revision seeks to take account of the important impact of this article on the enjoyment by women of the human rights protected under the Covenant.

2. Article 3 implies that all human beings should enjoy the rights provided for in the Covenant, on an equal basis and in their totality. The full effect of this provision is impaired whenever any person is denied the full and equal enjoyment of any right. Consequently, States should ensure to men and women equally the enjoyment of all rights provided for in the Covenant.

3. The obligation to ensure to all individuals the rights recognized in the Covenant, established in articles 2 and 3 of the Covenant, requires that State parties take all necessary steps to enable every person to enjoy those rights. These steps include the removal of obstacles to the equal enjoyment each of such rights, the education of the population and of state officials in human rights and the adjustment of domestic legislation so as to give effect to the undertakings set forth in the Covenant. The State party must not only adopt measures of protection but also positive measures in all areas so as to achieve the effective and equal empowerment of women. States parties must provide information regarding the actual role of women in society so that the Committee may ascertain what measures, in addition to legislative provisions, have been or should be taken to give effect to these obligations, what progress has been made, what difficulties are encountered and what steps are being taken to overcome them.

4. State parties are responsible for ensuring the equal enjoyment of rights without any discrimination. Articles 2 and 3 mandate States parties to take all steps necessary, including the prohibition of discrimination on the ground of sex, to put an end to discriminatory actions both in the public and the private sector which impair the equal enjoyment of rights.

5. Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes. The subordinate role of women in some countries is illustrated by the high incidence of pre-natal sex selection and abortion of female fetuses. States parties should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all

Covenant rights. States parties should furnish appropriate information on those aspects of tradition, history, cultural practices and religious attitudes which jeopardise, or may jeopardise, compliance with article 3, and indicate what measures they have taken or intend to take to overcome such factors.

6. In order to fulfil the obligation set forth in article 3 States parties should take account of the factors which impede the equal enjoyment by women and men of each right specified in the Covenant. To enable the Committee to obtain a complete picture of the situation of women in each State party as regards the implementation of the rights in the Covenant, this general comment identifies some of the factors affecting the equal enjoyment by women of the rights under the Covenant, and spells out the type of information that is required with regard to these various rights.

7. The equal enjoyment of human rights by women must be protected during a state of emergency (article 4). States parties which take measures derogating from their obligations under the Covenant in time of public emergency, as provided in article 4, should provide information to the Committee with respect to the impact on the situation of women of such measures and should demonstrate that they are non-discriminatory.

8. Women are particularly vulnerable in times of internal or international armed conflicts. States parties should inform the Committee of all measures taken during these situations to protect women from rape, abduction and other forms of gender based violence.

9. In becoming parties to the Covenant, States undertake, in accordance with article 3, to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the Covenant, and in accordance with article 5, nothing in the Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights provided for in article 3, or at limitations not covered by the Covenant. Moreover, there shall be no restriction upon or derogation from the equal enjoyment by women of all fundamental human rights recognized or existing pursuant to law, conventions, regulations or customs, on the pretext that the Covenant does not recognize such rights or that it recognizes them to a lesser extent.

10. When reporting on the right to life protected by article 6, States parties should provide data on birth rates and on pregnancy and childbirth-related deaths of women. Gender-disaggregated data should be provided on infant mortality rates. States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undertake life-threatening clandestine abortions. States parties should also report on measures to protect women from practices, that violate their right to life, such as female infanticide, the burning of widows and dowry killings. The Committee also wishes to have information on the particular impact on women of poverty and deprivation that may pose a threat to their lives.

11. To assess compliance with article 7 of the Covenant, as well as with article 24, which mandates special protection for children, the Committee needs to be provided information on national laws and practice with regard to domestic and other types of violence against women, including rape. It also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee information on measures to prevent forced abortion or forced sterilization. In States parties where the practice of genital mutilation exists information on its extent and on measures to eliminate it should be provided. The information provided by States parties on all these issues should include measures of protection, including legal remedies, for women whose rights under article 7 have been violated.

12. Having regard to their obligations under article 8, States parties should inform the Committee of measures taken to eliminate trafficking of women and children, within the country or across borders, and forced prostitution. They must also provide information on measures taken to protect women and children, including foreign women and children, from slavery, disguised inter alia as domestic or other kinds of personal service. States parties where women and children are recruited, and from which they are taken, and States parties where they are received should provide information on measures, national or international, which have been taken in order to prevent the violation of women's and children's rights.

13. States parties should provide information on any specific regulation of clothing to be worn by women in public. The Committee stresses that such regulations may involve a violation of a number of rights guaranteed by the Covenant, such as:

    - article 26, on non-discrimination;
    - article7, if corporal punishment is imposed in order to enforce such a regulation;
    - article 9, when failure to comply with the regulation is punished by arrest;
    - article 12, if liberty of movement is subject to such a constraint;
    - article 17, which guarantees all persons the right to privacy without arbitrary or unlawful interference;
    - articles 18 and 19, when women are subjected to clothing requirements that are not in keeping with their religion or their right of self-expression; and, lastly,
    - article 27, when the clothing requirements conflict with the culture to which the woman can lay a claim.

14. With regards to article 9 States parties should provide information on any laws or practices which may deprive women of their liberty on an arbitrary or unequal basis, such as by confinement within the house. (See General Comment No 8 paragraph 1.)

15. As regards articles 7 and 10, States parties must provide all information relevant to ensuring that the right of persons deprived of their liberty are protected on equal terms for men and women. In particular, States parties should report on whether men and women are separated in prisons and whether women are guarded only by female guards. States parties should also report about compliance with the rule that accused juvenile females shall be separated from adults and on any difference in treatment between male and female persons deprived of liberty, such as, for example, access to rehabilitation and education programmes and to conjugal and family visits. Pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at all times surrounding the birth and while caring for their newly-born children; States parties should report on facilities to ensure this and on medical and health care for such mothers and their babies.

16. As regards article 12, States parties should provide information on any legal provision or any practice which restricts women's right to freedom of movement as, for example, the exercise of marital powers over the wife or parental powers over adult daughters, legal or de facto requirements which prevent women from travelling such as the requirement of consent of a third party to the issuance of a passport or other type of travel documents to an adult woman. States parties should also report on measures taken to eliminate such laws and practices and to protect women against them, including reference to available domestic remedies (See General Comment No 27 paragraphs 6 and 18)

17. States parties should ensure that alien women are accorded on an equal basis the right to submit reasons against their expulsion, and to have their case reviewed as provided in article 13. In this regard, they should be entitled to submit reasons based on gender specific violations of the Covenant such as those mentioned in paragraphs [10 and 11] above.

18. State parties should provide information to enable the Committee to ascertain whether access to justice and the right to a fair trial, provided for in article 14, are enjoyed by women on equal terms to men. In particular States parties should inform the Committee whether there are legal provisions preventing women from direct and autonomous access to the courts (Case 202/1986, Ato del Avellanal v. Peru (views of 28 October 1988).; whether women may give evidence as witnesses on the same terms as men; and whether measures are taken to ensure women equal access to legal aid, in particular in family matters. States parties should report on whether certain categories of women are denied the enjoyment of the presumption of innocence under article 14, paragraph 2, and on the measures which have been taken to put an end to this situation.

19. The right of everyone under article 16 to be recognized everywhere as a person before the law is particularly pertinent for women, who often see it curtailed by reason of sex or marital status. This right implies that the capacity of women to own property, to enter into a contract or to exercise other civil rights may not be restricted on the basis of marital status or any other discriminatory ground. It also

implies that women may not be treated as objects to be given together with the property of the deceased husband to his family. States must provide information on laws or practices that prevent women from being treated or from functioning as full legal persons and the measures taken to eradicate laws or practices that allow such treatment.

20. States parties must provide information to enable the Committee to assess the effect of any laws and practices that may interfere with women's right to enjoy privacy and other rights protected by article 17 on the basis of equality with men. An example of such interference arises where the sexual life of a woman is taken into consideration to decide the extent of her legal rights and protections, including protection against rape. Another area where States may fail to respect women's privacy relates to their reproductive functions, for example, where there is a requirement for the husband's authorization to make a decision in regard to sterilization, where general requirements are imposed for the sterilization of women, such as having a certain number of children or being of a certain age, or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion. In these instances, other rights in the Covenant, such as those of articles 6 and 7, might also be at stake. Women's privacy may also be interfered with by private actors, such as employers who request a pregnancy test before hiring a woman. States parties should report on any laws and public or private actions that interfere with the equal enjoyment by women of the rights under article 17, and on the measures taken to eliminate such interference and to afford women protection from any such interference.

21. States parties must take measures to ensure that freedom of thought, conscience and religion, and the freedom to adopt the religion or belief of one's choice -- including the freedom to change religion or belief and to express one's religion or belief – will be guaranteed and protected in law and in practice for both men and women, on the same terms and without discrimination. These freedoms protected by article 18, must not be subject to restrictions other than those authorized by the Covenant, and must not be constrained by, inter alia, rules requiring permission from third parties, or by interference from fathers, husbands, brothers or others. Article 18 may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion; States parties should therefore provide information on the status of women as regards their freedom of thought, conscience and religion, and indicate what steps they have taken or intend to take both to eliminate and prevent infringements of these freedoms in respect of women and to protect their rights against any discrimination.

22. In relation to article 19 States parties should inform the Committee of any laws or other factors which may impede women from exercising the rights protected under this provision on an equal basis. As the publication and dissemination of obscene and pornographic material which portrays women and girls as objects of violence or degrading or inhuman treatment is likely to promote these kinds of treatment of women and girls, States parties should provide information about legal measures to restrict the publication or dissemination of such material.

23. States are required to treat men and women equally in regard to marriage in accordance with article 23, which has been elaborated further by General Comment 19 (1990). Men and women have the right to enter into marriage only with their free and full consent, and States have an obligation to protect the enjoyment of this right on an equal basis. Many factors may prevent women from being able to make the decision to marry freely. One factor relates to the minimum age for marriage. That age should be set by the State on the basis of equal criteria for men and women. These criteria should ensure women's capacity to make an informed and uncoerced decision. A second factor in some States may be that either by statutory or customary law a guardian, who is generally male, consents to the marriage instead of the woman herself, thereby preventing women from exercising a free choice.

24. A different factor that may affect women's right to marry only when they have given free and full consent is the existence of social attitudes which tend to marginalize women victims of rape and put pressure on them to agree to marriage. A woman's free and full consent to marriage may also be undermined by laws which allow the rapist to have his criminal responsibility extinguished or mitigated if he marries the victim. States parties should indicate whether marrying the victim extinguishes or mitigates criminal responsibility and in the case in which the victim is a minor whether the rape reduces the marriageable age of the victim, particularly in societies where rape victims have to endure marginalization from society. A different aspect of the right to marry may be affected when States impose restrictions on remarriage by women as compared to men. Also the right to choose one's spouse may be restricted by laws or practices that prevent the marriage of a woman of a particular religion with a man who professes no religion or a different religion. States should provide information on these laws and practices and on the measures taken to abolish the laws and eradicate the practices which undermine the right of women to marry only when they have given free and full consent. It should also be noted that equality of treatment with regard to the right to marry implies that polygamy is incompatible with this principle. Polygamy violates the dignity of women. It is an inadmissible discrimination against women. Consequently, it should be definitely abolished wherever it continues to exist.

25. To fulfill their obligations under article 23, paragraph 4, States must ensure that the matrimonial regime contains equal rights and obligations for both spouses, with regard to the custody and care of children, the children's religious and moral education, the capacity to transmit to children the parent's nationality, and the ownership or administration of property, whether common property or property in the sole ownership of either spouse. States should review their legislation to ensure that married women have equal rights in regard to the ownership and administration of such property, where necessary. Also, States should ensure that no sex-based discrimination occurs in respect of the acquisition or loss of nationality by reason of marriage, of residence rights and of the right of each spouse to retain the use of his or her original family name or to participate on an equal basis in the choice of a new family name. Equality during marriage implies that husband and wife should participate equally in responsibility and authority within the family.

26. States must also ensure equality in regard to the dissolution of marriage, which excludes the possibility of repudiation. The grounds for divorce and annulment should be the same for men and women, as well as decisions with regard to property distribution, alimony and the custody of children. The need to maintain contact between children and the non-custodian parent, should be based on equal considerations. Women should also have equal inheritance rights to those of men when the dissolution of marriage is caused by the death of one of the spouses.

27. In giving effect to recognition of the family in the context of article 23, it is important to accept the concept of the various forms of family, including unmarried couples and their children and single parents and their children and to ensure the equal treatment of women in these contexts (General Comment 19 paragraph 2 last sentence). Single parent families frequently consist of a single woman caring for one or more children, and States parties should describe what measures of support are in place to enable her to discharge her parental functions on the basis of equality with a man in a similar position.

28. The obligation of states to protect children (article 24) should be carried out equally for boys and girls. States should report on measures taken to ensure that girls are treated equally to boys in education, in feeding and in health care, and provide the Committee with disaggregated data in this respect. States should eradicate, both through legislation and any other appropriate measures, all cultural or religious practices which jeopardize the freedom and well-being of female children.

29. The right to participate in the conduct of public affairs is not fully implemented everywhere on an equal basis. States must ensure that the law guarantees to women article 25 rights on equal terms with men and take effective and positive measures to promote and ensure women's participation in the conduct of public affairs and in public office, including appropriate affirmative action. Effective measures taken by States parties to ensure that all persons entitled to vote are able to exercise that right should not be discriminatory on the grounds of sex. The Committee requires States parties to provide statistical information on the percentage of women in publicly elected offices including the legislature as well as in high-ranking civil service positions and the judiciary.

30. Discrimination against women is often intertwined with discrimination on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status. States parties should address the ways in which any instances of discrimination on other grounds affect women in a particular way, and include information on the measures taken to counter these effects.

31. The right to equality before the laws and freedom from discrimination, protected by article 26, requires States to act against discrimination by public and private agencies in all fields. Discrimination against women in areas such as social security laws - Case 172/84, Broeks v. Netherlands (views of 9 April 1987; case 182/84, Zwaan de Vries v. The Netherlands, (views of 9 April 1987); case 218/1986, Vos v.

The Netherlands (views of 29 March 1989) - as well as in the area of citizenship or rights of non-citizens in a country - Case 035/1978, Aumeeruddy-Cziffra et al v. Mauritius (views adopted 9 April 1981) - violates article 26. The commission of so called "honour crimes" which remain unpunished, constitutes a serious violation of the Covenant and in particular of articles 6, 14 and 26. Laws which impose more severe penalties on women than on men for adultery or other offences also violate the requirement of equal treatment. The Committee has also often observed in reviewing States reports that a large proportion of women are employed in areas which are not protected by labor laws, that prevailing customs and traditions discriminate against women, particularly with regard to access to better paid employment and to equal pay for work of equal value. States should review their legislation and practices and take the lead in implementing all measures necessary in order to eliminate discrimination against women, in all fields, for example by prohibiting discrimination by private actors in areas such as employment, education, political activities and the provision of accommodation, goods and services. States parties should report on all these measures and provide information on the remedies available to victims of such discrimination.

32. The rights which persons belonging to minorities enjoy under article 27 of the Covenant in respect of their language, culture and religion do not authorize any State, group or person to violate the right to equal enjoyment by women of any Covenant rights, including the right to equal protection of the law. States should report on any legislation or administrative practices related to membership in a minority community that might constitute an infringement of the equal rights of women under the Covenant - Case 24/1977 Lovelace v. Canada, (views adopted July 1981) - and on measures taken or envisaged to ensure the equal right of men and women to enjoy all civil and political rights in the Covenant. Likewise, States should report on measures taken to discharge their responsibilities in relation to cultural or religious practices within minority communities that affect the rights of women. In their reports, States parties should pay attention to the contribution made by women to the cultural life of their communities.

Appendix 9

Committee on the Elimination of Racial Discrimination, General Recommendation 25: Gender Related Dimensions of Racial Discrimination

CERD, *General Recommendation 25*, UN GAOR, 2000, UN Doc. A/55/18, Annex V, p. 152.

1. The Committee notes that racial discrimination does not always affect women and men equally or in the same way. There are circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men. Such racial discrimination will often escape detection if there is no explicit recognition or acknowledgement of the different life experiences of women and men, in areas of both public and private life.

2. Certain forms of racial discrimination may be directed towards women specifically because of their gender, such as sexual violence committed against women members of particular racial or ethnic groups in detention or during armed conflict; the coerced sterilization of indigenous women; abuse of women workers in the informal sector or domestic workers employed abroad by their employers. Racial discrimination may have consequences that affect primarily or only women, such as pregnancy resulting from racial bias-motivated rape; in some societies women victims of such rape may also be ostracized. Women may also be further hindered by a lack of access to remedies and complaint mechanisms for racial discrimination because of gender-related impediments, such as gender bias in the legal system and discrimination against women in private spheres of life.

3. Recognizing that some forms of racial discrimination have a unique and specific impact on women, the Committee will endeavour in its work to take into account gender factors or issues which may be interlinked with racial discrimination. The Committee believes that its practices in this regard would benefit from developing, in conjunction with the States parties, a more systematic and consistent approach to evaluating and monitoring racial discrimination against women, as well as the disadvantages, obstacles and difficulties women face in the full exercise and enjoyment of their civil, political, economic, social and cultural rights on grounds of race, colour, descent, or national or ethnic origin.

4. Accordingly, the Committee, when examining forms of racial discrimination, intends to enhance its efforts to integrate gender perspectives, incorporate gender analysis, and encourage the use of gender-inclusive language in its sessional working methods, including its review of reports submitted by States parties, concluding observations, early warning mechanisms and urgent action procedures, and general recommendations.

5. As part of the methodology for fully taking into account the gender-related dimensions of racial discrimination, the Committee will include in its sessional

working methods an analysis of the relationship between gender and racial discrimination, by giving particular consideration to:

(a) The form and manifestation of racial discrimination;

(b) The circumstances in which racial discrimination occurs;

(c) The consequences of racial discrimination; and

(d) The availability and accessibility of remedies and complaint mechanisms for racial discrimination.

6. Noting that reports submitted by States parties often do not contain specific or sufficient information on the implementation of the Convention with respect to women, States parties are requested to describe, as far as possible in quantitative and qualitative terms, factors affecting and difficulties experienced in ensuring the equal enjoyment by women, free from racial discrimination, of rights under the Convention. Data which have been categorized by race or ethnic origin, and which are then disaggregated by gender within those racial or ethnic groups, will allow the States parties and the Committee to identify, compare and take steps to remedy forms of racial discrimination against women that may otherwise go unnoticed and unaddressed.

Appendix 10

Sample Application for Individual Petitions to Appropriate UN-Based Treaty-Monitoring Bodies

Various treaty-based bodies of the United Nations Human Rights System offer avenues of communication through which individuals or groups of individuals, who claim to be victims of human rights violations, may lodge a complaint against their State. Specifically, the available communications, as referred to in the manual, are as follows:

1. The Optional Protocol to the International Covenant on Civil and Political Rights outlines, in Articles 1 through 5, a complaints procedure to the Human Rights Committee for individuals or groups of individuals whose State is a party to both the Political Covenant and the Optional Protocol.
2. The Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women provides, in Articles 2 through 7, a Communications Procedure to CEDAW for individuals or groups of individuals whose State is a party to both the Women's Convention and the Optional Protocol.
3. Article 14 of the International Convention on the Elimination of All Forms of Racial Discrimination establishes a procedure which makes it possible for an individual or a groups of persons who claim to be victims of racial discrimination to lodge a complaint with the Committee on the Elimination of Racial Discrimination (CERD) against their State. This may only be done if the State concerned is a party to the Convention and has declared that it recognizes the competence of CERD to receive such complaints.

Each procedure referred to above should be examined carefully to ensure that a communication or complaint meets the technical and substantive requirements imposed by that particular system. For communications to the Human Rights Committee, for instance, a sample form is available,[1] however its use is not required.

The following sample form can by utilized as a model for any of the communications procedures to the treaty-based bodies discussed, with the caveat that careful attention must be paid to the specific scope of each. For example, some procedures permit any person or NGO to raise questions of human rights violations; others permit only the alleged victim or a direct representative to file a complaint. The requirement to exhaust domestic remedies is common to nearly every procedure, but its interpretation varies considerably.[2]

[1] See www.unhchr.ch/html/menu2/complain.htm.

[2] H. Hannum, ed., Guide to International Human Rights Practice, 3rd ed., Transnational Publishers, Inc. and The Procedural Aspects of International Law Institute, 1999.

Model Communication to UN-Based Treaty Bodies

Date: ……

Communication to:

Type Address Here

Note: Communications to the Human Rights Committee and Committee on the Elimination of Racial Discrimination should be addressed as follows (indicate Committee for which communication is intended):

OHCHR-UNOG
CH-1211 Geneva 10
SWITZERLAND
Tel: (41) (22) 917-9000; fax: (41) (22) 917-9022

Communications to the Committee on the Elimination of Discrimination against Women should be addressed to:

2 UN Plaza, DC2-12th Floor
New York, NY 10017
USA
Tel.: (1) (212) 963-3177; fax: (1) (212) 963-3463

submitted for consideration under the…

I. Information concerning the author of the communication

Name: First Name(s):

Nationality: Profession:

Date and Place of Birth:

Present address or whereabouts:

Address for exchange of confidential correspondence (if other than present address):

Submitting the communication as:

(a) Victim of the violation or violations set forth below
……

(b) Appointed representative/legal counsel of the alleged victim(s)
……

(c) Other
……

If box (c) is marked, the author should explain:

(i) In what capacity s/he is acting on behalf of the victim(s) (e.g. family relationship or other personal links with the alleged victim(s)):

(ii) Why the victim(s) is (are) unable to submit the communication him/her self (themselves):

An unrelated third party having no link to the victim(s) cannot submit a communication on their behalf.

II. Information concerning the alleged victim(s) (if other than author)

Name: First Name:

Nationality: Profession:

Date and place of birth:

Present address or whereabouts:

III. State concerned/articles violated/domestic remedies

Name of the State party (country) against which the communication is directed:

Articles allegedly violated:

Steps taken by or on behalf of the alleged victim(s) to exhaust domestic remedies – resource to the courts or other public authorities, when and with what results (if possible, enclose copies of all relevant judicial or administrative decisions):

If domestic remedies have not been exhausted, explain why:

IV. Other international procedures

Has the same matter been submitted for examination under another procedure of international investigation or settlement (e.g. the Inter-American Commission of Human Rights, the European Commission on Human Rights)? If so, when and with what results?

V. Facts of the claim

Detailed description of the facts of the alleged violation or violations (including relevant dates):[3]

Author's signature……

[3] Add as many pages as needed for this description.