

# Surviving Pregnancy and Childbirth

## An International Human Right

*The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times.... [W]omen'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...."*

—Rebecca J. Cook & Bernard M. Dickens, World Health Organization,  
*Advancing Safe Motherhood Through Human Rights* (2001)

The right to survive pregnancy and childbirth is implicit in women's fundamental human right to life. Women's enjoyment of that right is dependent upon their ability to exercise three other basic human rights: the rights to health care, non-discrimination and reproductive self-determination. Holding governments legally accountable for the realization of these rights is a powerful means of overcoming acceptance of death during pregnancy or childbirth as an unavoidable risk of womanhood. This briefing paper approaches maternal survival as a human right, and offers the following three conclusions:

- Governments have a duty under international human rights law to work to ensure women's survival of pregnancy and childbirth
- Laws and policies guaranteeing access to high-quality reproductive health services, non-discrimination and autonomy in reproductive decision-making are essential to ensuring safe pregnancy and childbirth
- The international community should fulfill commitments made at international conferences and other fora to address the factors contributing to maternal mortality

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Photo courtesy of Deborah Dudley

## I. Introduction

Every year, more than a half-million women lose their lives to complications of pregnancy or childbirth.<sup>1</sup> Ninety-nine percent of these women live in low-income countries, with one in 16 women in Sub-Saharan Africa dying from pregnancy-related causes.<sup>2</sup> Death on this scale is not an inevitable danger of pregnancy and childbirth—it

is a preventable loss of life and the tragic result of policy decisions that too often neglect, devalue and discriminate against women. Advocates can pressure governments to reverse this trend by holding them accountable for their duties under international law to ensure women’s enjoyment of the right to survive pregnancy and childbirth. Use of the language of “rights” brings into focus governments’ binding obligations under international and national law to ensure a woman’s safety throughout pregnancy and childbirth. Failure to meet these obligations constitutes a violation of treaty commitments and other binding international norms, as well as national-level constitutional and legislative obligations.

This briefing paper discusses the international legal standards for the rights to life, health, non-discrimination and reproductive self-determination and identifies governments’ corresponding duties to ensure women’s enjoyment of those rights. It provides global illustrations of the toll that inadequate health-care delivery, pervasive discrimination and denials of reproductive decision-making take on women’s lives and health. It concludes with a brief discussion of the gap between the international community’s stated commitments to promoting maternal survival and its actions to that end thus far.

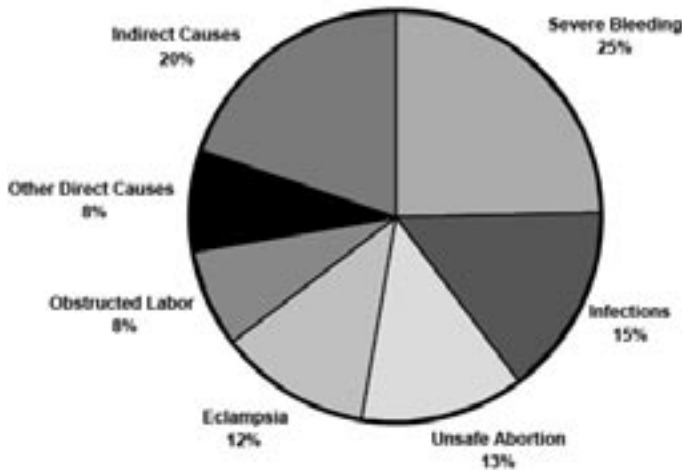
***Every minute, a woman somewhere dies in pregnancy or childbirth. This adds up to more than 500,000 maternal deaths every year.<sup>3</sup>***

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***The World Health Organization defines a maternal death 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.”<sup>4</sup>***

# Pregnancy and Childbirth: A Global Snapshot

## CAUSES OF PREGNANCY AND CHILDBIRTH-RELATED DEATHS



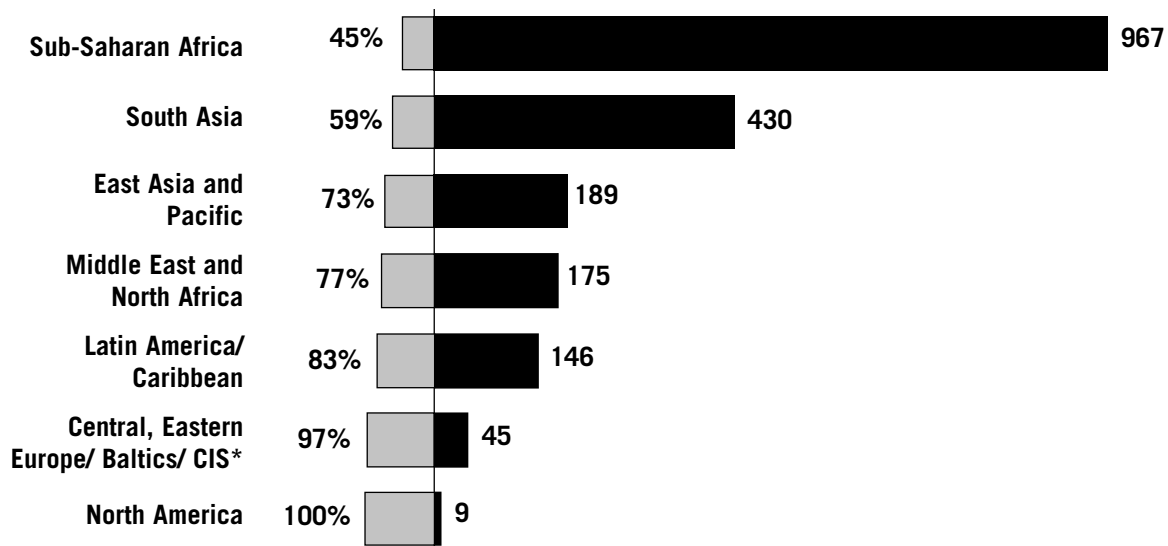
Lifetime risk of maternal death by United Nations Millennium Development Goal Regions:<sup>5</sup>

Africa	1 in 20
Asia	1 in 94
Latin America and the Caribbean	1 in 160
Oceania	1 in 83
Developed Regions (Europe, Canada, USA, Japan, Australia, and New Zealand, which are excluded from regional totals)	1 in 2,800

Source: World Health Organization, Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF/World Bank Statement, Geneva, 1999. Available at Population Reference Bureau, *Graphic Banks* [http://www.prb.org/presentations/f\\_causes-matern-mortality.ppt](http://www.prb.org/presentations/f_causes-matern-mortality.ppt)

## SKILLED CARE AT DELIVERY AND MATERNAL DEATHS: REGIONAL COMPARISONS<sup>6</sup>

Percent of births assisted by skilled attendants | Number of maternal deaths per 200,000 live births



\*Commonwealth of Independent States (former Soviet Union)

Source: Population Reference Bureau, *Making Motherhood Safer*, 2002.

## II. International Human Rights Framework

The most fundamental of human rights guarantees—the right to life—is indispensably connected to the human rights to health, non-discrimination and reproductive self-determination. The ability of women to survive pregnancy and childbirth—indeed, exercise their right to life—is contingent upon their access to high-quality reproductive health care, freedom from social, cultural, economic and legal discrimination, and autonomy over decisions relating to their reproductive lives. Governments’ failure to ensure these conditions constitutes a deprivation of fundamental human rights guarantees to which all women are entitled under international law.

### A. RIGHT TO LIFE

In most low-income countries, maternal mortality accounts for the greatest proportion of deaths among women of reproductive age.<sup>7</sup> The vast majority of these deaths are preventable.<sup>8</sup> International guarantees of the right to life mean that governments must not only refrain from arbitrary killings, but must work proactively to safeguard their citizens from arbitrary and preventable losses of life,<sup>9</sup> including preventable maternal death.<sup>10</sup> In order to uphold these duties, governments must approach maternal death as a matter of human rights and strengthen their commitment to women’s reproductive health through laws, policies and programs.

***“I do not believe for one minute, that if men were dying in their prime in these numbers, so little would be being done.”***

James Wolfensohn, President, The World Bank,  
World Health Day, April 7, 1998

Denials of women’s right to life are alarmingly evident in **Afghanistan**, where one in six women dies from pregnancy-related causes.<sup>11</sup> The combined effects of over 20 years of war, three droughts and six years of Taliban rule have had devastating health consequences for Afghan women. Complications of pregnancy and childbirth account for half of all deaths of Afghan women of childbearing age.<sup>12</sup> A comparable state of crisis exists in countries of Sub-

Saharan Africa, especially where armed conflict has contributed to women’s vulnerability during pregnancy.<sup>13</sup> In **Sierra Leone**, the risk of death during pregnancy and childbirth is as high as one in six.<sup>14</sup> But the risk of maternal mortality is unacceptably high even in many countries that have enjoyed relative peace, including **Mali**, where an estimated one in 10 women dies of pregnancy-related causes.<sup>15</sup>

It is important to note that in countries with statistics indicating a relatively low maternal mortality ratio, there may be segments of the population—particularly low-income and rural women and members of minority groups—that experience higher rates of maternal mortality. This is true in the **United States**, where the Centers for Disease Control reports that African-American women are three to four times more likely than white women to die of pregnancy-related causes.<sup>16</sup>

### B. RIGHT TO HEALTH CARE

Access to high-quality reproductive health services is crucial to efforts to reduce maternal mortality and is itself a protected international human right. Experts have identified a number of health-care interventions that contribute to a reduction in maternal mortality, including ensuring access to:

- pre- and post-natal care
- trained attendants at birth
- emergency obstetric care
- family planning

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International law guarantees all persons “the highest attainable standard of physical and mental health.”<sup>17</sup> The United Nations Committee on Economic, Social and Cultural Rights has acknowledged that the right to health necessarily gives rise to a government duty to provide health-care services. It has stated that fulfillment of the right to health care depends upon the “availability, accessibility, acceptability and quality” of health care for all individuals and “the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”<sup>18</sup>

Yet at least 35% of women in low-income countries receive no pre-natal care during pregnancy, almost 50% give birth without a skilled attendant and 70% receive no postpartum care in the six weeks following delivery.<sup>19</sup> The inadequacy of health-care services in low-income countries reflects the reality that a country’s limited financial resources, while not the sole determinant, is a significant contributing factor of its capacity to reduce maternal mortality. A human rights approach to maternal mortality, therefore, requires consideration of the obligations of wealthier nations to improve access to health care in low-income countries. The Economic and Social Rights Committee has emphasized the duty of wealthy countries to promote enjoyment of economic, social, and cultural rights internationally. In its General Comment on the Right to Health, the committee stated:

*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....*<sup>20</sup>

Greater international cooperation is needed to ensure realization of the right to health care. The following subsections examine global shortfalls in availability, accessibility, acceptability and quality of maternal health care.

### 1. Availability of Care

A study of health-care facilities in **Nigeria, Ghana and Sierra Leone** found that women experienced long delays in receiving emergency obstetric treatment once they arrived at the facilities, and that such delays were a major contributing factor to maternal deaths.<sup>21</sup> The study attributed the long delays—ranging from a mean time of 2.6 to 15.5 hours—to a shortage or lack of essential supplies and equipment, including drugs, gloves, sutures, and anesthetic agents at the facilities. Patients were forced to wait while relatives tried to acquire the needed drugs and supplies in private pharmacies.<sup>22</sup>

***In Senegal’s Kaolak hospital, 80% of women needing blood transfusions and 64% of women needing anesthesia did not receive the required treatment because of the unavailability of supplies.***<sup>23</sup>

### 2. Accessibility of Care

Even where services and facilities exist, they may be prohibitively expensive and therefore inaccessible to many women. The World Bank has estimated that governments need only commit US\$2 per person, per year, to ensure basic and acceptable maternal health services.<sup>24</sup> With support from the international community, governments can take immediate steps to allocate funds to ensure access to these basic services.

Physical barriers to access, such as the lack of transportation, are often extensions of the economic factors that prevent women from obtaining the high-quality reproductive health care they need. The women who suffer the greatest risk of maternal death live in low-income countries, large regions of which are often rural and have little or poor infrastructure. Rural roads



## In Bolivia, Investing in Women's Health Pays Off

The benefits of devoting resources to women's reproductive health have been immeasurable. In **Bolivia**, where maternal mortality rates are among the highest in Latin America,<sup>25</sup> a 1996 study revealed that high medical fees prevented mostly low-income women from receiving necessary health care.<sup>26</sup> Women who gave birth in public health facilities had to pay medical fees, anesthetic and antibiotic costs, and the cost of surgical supplies, including gloves and surgical drapes.<sup>27</sup> In an effort to improve the quality of the nation's maternal

and child health, the Bolivian government developed and implemented a national insurance program under which pregnant women and children under five years of age would receive free health services. Coverage for pregnant women would include ante-natal visits, hospital delivery, treatment of obstetric complications and a post-natal consultation.<sup>28</sup> An assessment of the program in its second year of operation found that it had increased the use of maternity care, especially among low-income women and girls.<sup>29</sup>

Photo courtesy of UN Photo Archive

are often in need of rehabilitation and vehicles are few or nonexistent. Existing facilities are usually concentrated around urban areas;<sup>30</sup> most rural women live more than five kilometers from the nearest hospital.<sup>31</sup> In a community-based study of maternal mortality in **Zimbabwe** between 1989 to 1990, unavailability of transportation contributed to 28% of deaths in the rural study area and 3% of deaths in the urban study area.<sup>32</sup> In the rural **Tanzanian** region of Mwanza, research shows that lack of ready access to inexpensive transportation is the most important barrier women face during obstetric emergencies.<sup>33</sup>

### 3. Acceptability of Care

Age- or culturally-inappropriate health-care services can serve as further barriers to care for pregnant women. Among the Saraguro Indians in **Ecuador**, formal health services have been shunned because hospitals are thought to violate women's privacy during childbirth and health providers are overwhelmingly male.<sup>34</sup> In studies of the indigenous Mayan population in **Guatemala**, research shows that Mayan women avoid family planning programs not because they do not want the services, but because they are rarely accessible or culturally- and language-appropriate.<sup>35</sup> In Guatemala, very few institutions provide information or services in any of the country's 24 indigenous languages.<sup>36</sup>

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*men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.*<sup>40</sup>

### 4. Quality of Care

The poor quality of health-care services—including poorly-trained or disrespectful and uncaring attitudes of medical staff, lack of privacy, deteriorating facilities, inconvenient operating hours, and restrictions on who may stay with a woman at a health-care facility<sup>37</sup>—dissuade many women from utilizing maternal health services even where they are available and accessible. In Masvingo, **Zimbabwe**, community-based research shows that a significant proportion of maternal deaths are caused by “avoidable factors,” including failure by health-care workers to identify women suffering from serious complications and to refer them to a higher level of the health-care system.<sup>38</sup> In **Egypt**, a study of 718 maternal deaths found that 92% of them could have been avoided if high quality care had been provided.<sup>39</sup>

### C. RIGHT TO NON-DISCRIMINATION

The scale of maternal death and disability across the world reflects a grave problem of systematic inequality and discrimination suffered by women throughout their life cycle, perpetuated by formal laws, policies and prejudicial social norms and practices harmful to women. The manifestations of discrimination that contribute to women’s vulnerability during pregnancy and childbirth are many, and include income disparities between men and women within the household, domestic violence, practices that are harmful to women, son preferences, and stereotyped perceptions of women as primarily mothers and nurturers.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defines discrimination against women as:

*[A]ny 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 ... on a basis of equality of*

Under CEDAW, governments must not only refrain from acts of discrimination against women, but they must work actively to “modify social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea or the superiority of either of the sexes or on stereotyped roles for men and women.”<sup>41</sup> The Convention on the Rights of the Child similarly requires states parties to “take all effective appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”<sup>42</sup>

Governments that legally sanction or fail to intervene in the practice of child marriage perpetrate one such form of discrimination against young girls and adolescents. Child marriage leads to early childbearing, which entails a number of health risks.<sup>43</sup> Young girls who bear children before their pelvises are fully developed often suffer complications, including protracted labor. Where these complications do not result in death, they may cause chronic injury, such as obstetric fistulae—holes between the birth canal and the bladder or rectum—which cause leaking of urine or feces, and thus render many sufferers outcasts from their families and communities.<sup>44</sup>

FC/FGM, most prevalent in West, Central and East Africa,<sup>45</sup> is another practice that is harmful to women. FC/FGM violates women’s bodily integrity and jeopardizes their safety during pregnancy and childbirth. The World Health Organization (WHO) estimates that between 100 and 140 million women and girls worldwide have undergone FC/FGM, and a further two million girls are at risk of undergoing the procedure every year.<sup>49</sup>



Photo courtesy of Richard Lord Photography

*In Bangladesh, where more than half of all girls are married before age 18 and the average age of marriage is 14, early childbearing is the leading risk factor for maternal death.<sup>46</sup> The maternal mortality ratio is as high as 300 to 450 per 100,000 live births.<sup>47</sup> Among adolescent girls, the figure is 580 per 100,000 live births.<sup>48</sup>*

Obstetric problems associated with FC/FGM include vulval and vaginal scarring, which can obstruct delivery.<sup>50</sup> In addition, infection and inflammation may occur at the time of the cutting, leading to vulval adhesions that narrow or obliterate the vaginal opening. Again, the result can be prolonged or obstructed labor.<sup>51</sup> A medical study of approximately 2000 Nigerian women that examined the relationship between obstetric complications at delivery and FC/FGM concluded that women who have undergone FC/FGM experience significantly more obstetric complications than women who have not.<sup>52</sup>

In addition to protecting women from gender discrimination, international law and policy documents recognize discrimination on the basis of economic status or residence outside urban areas. CEDAW calls upon governments to make special efforts to ensure that women in rural communities are not disadvantaged, specifically with regard to “access to adequate health care facilities, including information, counseling and services in family planning.”<sup>53</sup> The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has also recognized that for some women, “high fees for health care services ... distance from health care facilities and absence of convenient and affordable public transport” are barriers to services and are

themselves forms of discrimination.<sup>54</sup> These protections, as well as those adopted at international conferences, specifically target those at greatest risk in matters of sexual and reproductive health: young women, women living in poverty and women from rural or marginalized urban areas.

#### D. RIGHT TO REPRODUCTIVE SELF-DETERMINATION

The right to make informed decisions about one’s reproductive life is protected by the human right to reproductive self-determination as guaranteed by international law. This right is implicit in the rights to physical integrity, liberty, privacy and family life, and has been explicitly articulated in international conference documents and CEDAW as the right to determine the number and spacing of one’s children. Article 16 of CEDAW provides that states parties shall ensure men and women equally “[t]he 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.”<sup>55</sup> Protecting a woman’s right to reproductive self-determination requires states to guarantee access to a full range of:

- contraceptive choices
- reproductive health services, including safe abortion services
- information on family planning and sexual and reproductive health



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The failure of governments to ensure reproductive choice jeopardizes women's safety during pregnancy and childbirth. Such a failure may result from regulatory or legal barriers to contraceptive access or from inadequate funding to ensure that contraceptive methods are available to those unable to pay for them. In addition, cultural attitudes toward family planning—including resistance from spouses—may deter many women from using contraceptives. Where women are denied the means to control their fertility, they are more likely to experience

unwanted or unintended pregnancies, which may cause them to give birth at shorter intervals. Frequent and multiple births make women more physically vulnerable to complications of pregnancy and childbirth, thus increasing their risk of maternal death. In addition, unwanted or unintended pregnancies lead thousands of women who lack access to safe and legal abortion services to resort to illegal and unsafe abortion procedures.

### In India and South Africa, Abortion Is Legal but Not Always an Option

Liberal abortion laws do not necessarily guarantee women's access to safe abortion. In **India**, despite the legality of abortion on broad grounds, women often cannot or do not avail themselves of public abortion services for a number of reasons. Many women are unaware of their legal right to abortion or find the law complicated and confusing because of its numerous qualifications.<sup>56</sup> Abortion facilities are also concentrated in cities, rendering services unavailable for the almost 75% of the population who live in villages.<sup>57</sup> Where services are available, poor quality of care often deters women from using public facilities:

women have been mistreated, exploited, discouraged from obtaining abortion, given biased information and counseling, and have suffered violations of confidentiality and privacy by medical workers.<sup>58</sup> In **South Africa**, women experience similar denials of access to safe abortion, despite liberal abortion laws. It is estimated that nearly 6% of maternal deaths are caused by unsafe abortions.<sup>59</sup> Research shows that anti-abortion attitudes of health workers as well as women's lack of knowledge of their rights are major factors hindering women's access to legal abortions.<sup>60</sup>



Photo courtesy of Richard Lord Photography

Worldwide, unsafe abortion accounts for 13 percent of maternal deaths.<sup>61</sup> In **Nepal**, which had one of the most restrictive abortion laws in the world until its reform in September 2002,<sup>62</sup> unsafe abortion has been estimated to account for about half of all maternal deaths.<sup>63</sup>

Women's right to life entitles them to live through pregnancy and childbirth. Their rights to health care, nondiscrimination, and reproductive self-determination—the conditions necessary for maternal survival—are themselves protected under international law. This section has focused on governments' duty to promote women's surviv-

al of pregnancy and childbirth through legal and policy reform. Governments have acknowledged this duty at international conferences, where they have made individual and collective commitments to saving women's lives. While not legally binding on governments, the documents adopted at these conferences contribute to the advancement of international norms and can assist in interpreting the scope of human rights treaty provisions.<sup>64</sup> The next section discusses provisions relating to maternal survival in some of the main international conference documents.



### III. Global Commitments to Saving Women's Lives

In 2000, when the international community adopted the Millennium Development Goals as a framework for measuring development progress, it made reduction of maternal mortality a key priority.<sup>65</sup> Before that, the international community adopted agreements at the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women (Beijing Conference) that explicitly recognize the responsibility of governments to promote maternal survival, underscoring the urgency of such action. The ICPD Programme of Action, the principles of which states parties reaffirmed at the Beijing Conference one year later, states:

*All countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care ... the underlying causes of maternal morbidity and mortality should be identified and attention should be given to the development of strategies to overcome them....<sup>66</sup>*

Among the specific goals adopted at both the ICPD and Beijing Conference was the reduction of maternal mortality by one half of 1990 levels by the year 2000 and by a further one half by 2015.<sup>67</sup>

At the ICPD five-year review conference in 1999,

where lack of progress in meeting those benchmarks was apparent, governments renewed the commitments made at the ICPD and Beijing Conference and agreed upon “Key Actions” for further implementation, including:

*Ensur[ing] that reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care, well-equipped and adequately staffed maternal health care services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, postpartum care and family planning.<sup>68</sup>*

International actors, including the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Bank, and several NGOs, have taken joint action to strengthen programs aimed at ensuring "Safe Motherhood." The interagency group promotes the implementation of a comprehensive package of services to advance safe motherhood, which includes ante-natal care and counseling, skilled care during labor and delivery, post-partum care, family planning, abortion-related care, reproductive health education and services, and community education.<sup>69</sup> In addition, WHO has launched the "Making Pregnancy Safer" initiative, whose mission is to assist governments and partner agencies to ensure that "safe motherhood is prioritized within their policies and budgets, and that evidence-based norms and standards of care are appropriately applied."<sup>70</sup>

Despite its declared commitments, the international community has yet to ensure the health, safety and survival of pregnant women, or even meet targets for reduction of maternal mortality. To a large extent, what is missing is funding. A recent global study on the toll of unintended pregnancies on women's lives faulted the steep drop in worldwide family planning funds from the United States and unmet pledges from other high-income nations as contributing to more than 300 million unintended pregnancies and the maternal deaths of an estimated 700,000 women between 1995 and 2000.<sup>71</sup> The study found that more than one-third of these women died from problems associated with pregnancy, labor and delivery.<sup>72</sup> The majority—an estimated 400,000—died as a result of complications resulting from abortion carried out in unsafe, unsanitary and often illegal conditions.<sup>73</sup>

## IV. Conclusion

Women's fundamental human rights to life, health care, non-discrimination, and reproductive self-determination give rise to a governmental duty to create the conditions necessary for women's survival of pregnancy and childbirth. Not only are these rights protected in binding international human rights instruments, but the international community, at United Nations conferences, has committed itself to ensuring maternal survival and reproductive health. Governments must meet their commitments to the world's women, whose rights they are bound to promote and protect. Fulfilling women's right to survive pregnancy and childbirth—indeed, their right to life—means that governments must ensure women's access to high-quality, appropriate reproductive health care; abolish discriminatory laws, policies or social practices prejudicial to women and girls' health; and allow women to make autonomous decisions concerning their fertility and reproductive lives. Women and girls will stop dying in pregnancy and childbirth when governments' actions—not simply their rhetoric—reflect respect for and a commitment to women's fundamental human rights.

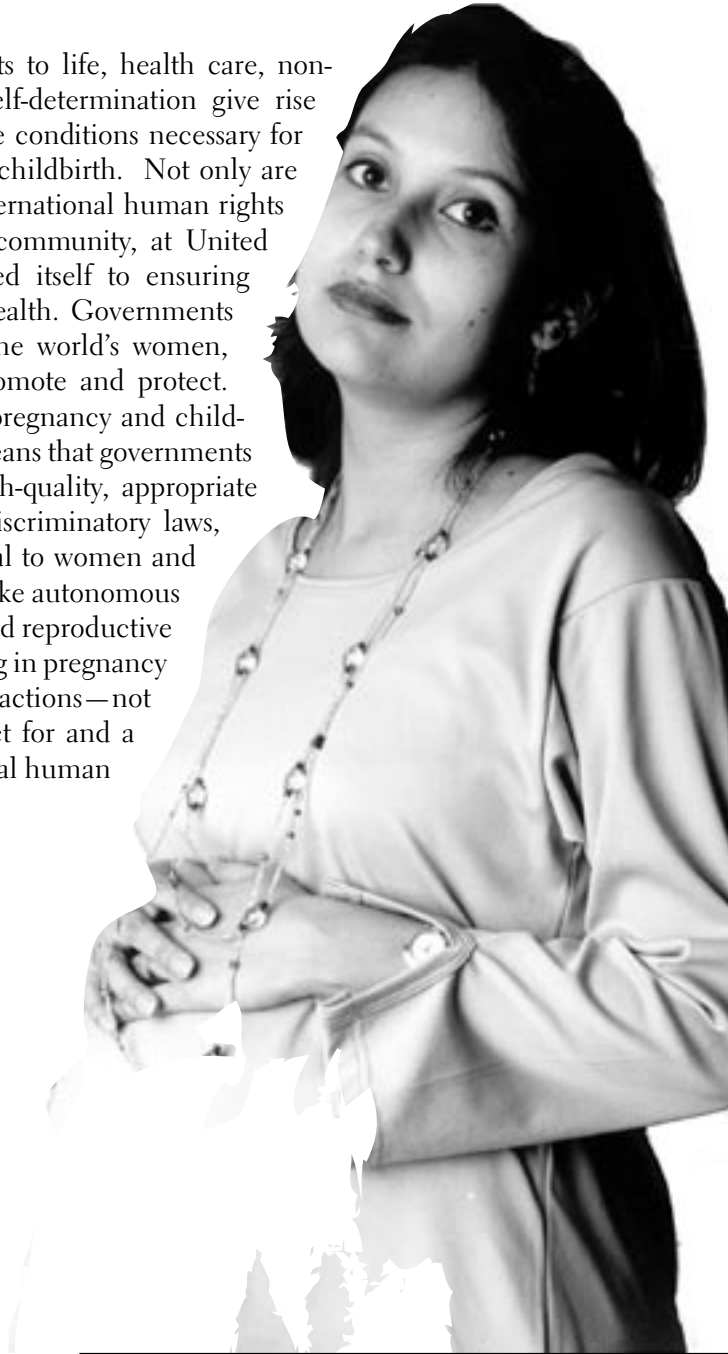


Photo courtesy of Deborah Dudley

Endnotes

- 1 WORLD HEALTH ORGANIZATION (WHO) ET AL., MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA 2, tab. 1 (2004) [hereinafter WHO ET AL., MATERNAL MORTALITY IN 1995].
- 2 *Id.* at 1.
- 3 *Id.*
- 4 WHO, INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS, 10TH REVISION 134 (1992).
- 5 WHO ET AL., MATERNAL MORTALITY IN 2000, *supra* note 1 at 2.
- 6 ELIZABETH I. RANSOM & NANCY V. YINGER, POPULATION REFERENCE BUREAU, MAKING MOTHERHOOD SAFER: OVERCOMING OBSTACLES ON THE PATHWAY TO CARE 18 (2002).
- 7 Ghada Hafez, WHO Regional Office for the Eastern Mediterranean, *Maternal Mortality: A Neglected and Socially Unjustifiable Tragedy*, EASTERN MEDITERRANEAN HEALTH JOURNAL, vol. 4, issue 1, 7-10 (1998).
- 8 WHO ET AL., REDUCTION OF MATERNAL MORTALITY: A JOINT WHO/UNFPA/UNICEF/WORLD BANK STATEMENT 1 (1999) [hereinafter WHO ET AL., REDUCTION OF MATERNAL MORTALITY].
- 9 Human Rights Committee, Gen. Comment 6, *The Right to Life*, para. 5 (1982) [hereinafter Human Rights Committee, Gen. Comment 6].
- 10 Human Rights Committee, Gen. Comment 28, *Equality of Rights Between Men and Women*, para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).
- 11 WHO ET AL., MATERNAL MORTALITY IN 2000, *supra* note 1 at 22, tab. G.
- 12 UNITED NATIONS CHILDREN'S FUND (UNICEF) ET AL., MATERNAL MORTALITY IN AFGHANISTAN: MAGNITUDE, CAUSES, RISK FACTORS AND PREVENTABILITY 4, 6 (2002) [hereinafter UNICEF ET AL., MATERNAL MORTALITY IN AFGHANISTAN].
- 13 WHO ET AL., MATERNAL MORTALITY IN 2000, *supra* note 1, at 22-26, tab. G.
- 14 *Id.* at 25, tab. G
- 15 *Id.* at 24, tab. G
- 16 Centers for Disease Control, *Factsheet: Pregnancy-Related Mortality Surveillance -- United States, 1991-1999* (Feb.20, 2003), available at <http://www.cdc.gov/od/oc/media/pressrel/fs030220.htm>.
- 17 International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, art. 12(1), U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (entered into force Mar. 23, 1976) [hereinafter Economic, Social and Cultural Rights Covenant].
- 18 Committee on Economic, Social and Cultural Rights (CESCR Committee), Gen. Comment No. 14, *The Right to the Highest Attainable Standard of Health*, para. 9, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR Committee, Gen. Comment 14].
- 19 WHO, COVERAGE OF MATERNITY CARE: A LISTING OF AVAILABLE INFORMATION, FOURTH EDITION (1997), cited in Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, available at <http://www.safemotherhood.org>.
- 20 CESCR Committee, Gen. Comment 14, *supra* note 18, para. 39 (citations omitted).
- 21 May Post, *Preventing Maternal Mortality through Emergency Obstetric Care*, Support for Analysis and Research in Africa (SARA) Issues Paper (1997).
- 22 *Id.*
- 23 *Id.*
- 24 PANOS, BIRTH RIGHTS: NEW APPROACHES TO SAFE MOTHERHOOD 26 (2001).
- 25 Population Council, *Latin America and the Caribbean, Bolivia*, at <http://www.popcouncil.org/americas/bolivia.html> (last updated Dec. 2, 2004).
- 26 RANSOM & YINGER, *supra* note 6, at 24, 25.
- 27 *Id.* at 20.
- 28 *Id.* at 25.
- 29 *Id.* at 25, 26.
- 30 May Post, *Preventing Maternal Mortality through Emergency Obstetric Care*, *supra* note 21.
- 31 Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, *supra* note 19.
- 32 May Post, *Preventing Maternal Mortality through Emergency Obstetric Care*, *supra* note 21.
- 33 *Id.* at 26.
- 34 J. Leslie and G.R. Gupta, *Utilization of Formal Services for Maternal Nutrition and Health Care*, International Center for Research on Women (1989), cited in Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, *supra* note 19.
- 35 GLORIA COSPÍN & ROSA XIQUITÁ, ASOCIACIÓN GUATEMALTECA DE EDUCACIÓN SEXUAL (AGES) & RICARDO VERNON, INOPAL III/POPULATION COUNCIL, ACCESS TO REPRODUCTIVE HEALTH SERVICES AND EDUCATION IN INDIGENOUS COMMUNITIES (1998).
- 36 *Id.*
- 37 C. AbouZahr, C. Vlassoff and A. Kumar, *Quality Health for Women: A Global Challenge*, HEALTH CARE FOR WOMEN INTERNATIONAL, vol. 17 (1996), cited in Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, *supra* note 19.

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- 38 S. Fawcus et al., *A Community-based Investigation of Avoidable Factors for Maternal Mortality in Zimbabwe*, STUDIES IN FAMILY PLANNING, vol. 27, no. 6 (1996), cited in Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, *supra* note 19.
- 39 Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services*, *supra* note 19.
- 40 Convention on the Elimination of all Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 1, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
- 41 *Id.* at art. 5(a).
- 42 Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, art. 1, U.N. Doc. A/44/49, (1989) (*entered into force* Sept. 2, 1990) [hereinafter Children's Rights Convention].
- 43 ALAN GUTTMACHER INSTITUTE (AGI), ISSUES IN BRIEF: RISKS AND REALITIES OF EARLY CHILDBEARING WORLDWIDE (1997) available at <http://www.guttmacher.org/pubs/ib10.html#7a>.
- 44 PANOS, *supra* note 24, at 7.
- 45 U. Larsen & F.E. Okonofua, *Female circumcision and obstetric complications*, INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS 256 (2002).
- 46 UN Wire, *Bangladesh: Early Marriage Linked to High Maternal Mortality*, UNICEF says, July 8, 2002.
- 47 *Id.*
- 48 *Id.*
- 49 WHO, *WHO Fact Sheet on FGM, Fact Sheet No. 241*, June 2000, available at <http://www.who.int/mediacentre/factsheets/fs241/en/>.
- 50 See DEP'T OF GENDER, WOMEN AND HEALTH, DEP'T OF REPRODUCTIVE HEALTH AND RESEARCH, FAMILY AND COMMUNITY HEALTH, WHO, MANAGEMENT OF PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD IN THE PRESENCE OF FEMALE GENITAL MUTILATION, REPORT OF A WHO TECHNICAL CONSULTATION, GENEVA, 15-17 OCT. 1997 at 9 (2001).
- 51 *See id.*
- 52 Larsen & Okonofua, *supra* note 45, at 256.
- 53 CEDAW, *supra* note 40, art. 14(2)(b).
- 54 CEDAW Committee, Gen. Recommendation 24, *Women and Health*, para. 21 (1999).
- 55 CEDAW, *supra* note 40, art. 16.1(e).
- 56 Manishe Gupta, Sunita Bandewar and Hemlata Pisal, *Abortion Needs of Women in India: A Case Study of Rural Maharashtra*, REPRODUCTIVE HEALTH MATTERS 77-86 (1997).
- 57 *Id.*
- 58 UNITED NATIONS, ABORTION POLICIES: A GLOBAL REVIEW vol. 2 (2002).
- 59 Ipas, *South Africa*, at [http://www.ipas.org/english/where\\_ipas\\_works/africa/south\\_africa/default.asp](http://www.ipas.org/english/where_ipas_works/africa/south_africa/default.asp) (last visited Jan. 20, 2004).
- 60 Sanjani Jane Varkey, *Abortion Services in South Africa: Available Yet Not Accessible to All*, FAMILY PLANNING PERSPECTIVES, vol. 6, no. 2 (2000).
- 61 Division of Reproductive Health, WHO, *Unsafe Abortion* 9 (3d. ed. 1998).
- 62 Center for Reproductive Rights, *King of Nepal Signs Historic Law Legalizing Abortion*, available at [http://www.reproductiverights.org/rfn\\_02\\_10.html#1](http://www.reproductiverights.org/rfn_02_10.html#1).
- 63 AGI, *The Guttmacher Report on Public Policy*, vol. 5, no. 2 (2002).
- 64 CENTER FOR REPRODUCTIVE RIGHTS, CLAIMING OUR RIGHTS: SURVIVING PREGNANCY AND CHILDBIRTH IN MALI 64 (2003).
- 65 UNFPA, *Millennium Development Goals (MDGs)*, at <http://www.unfpa.org/icpd/mdgs.htm> (last visited Jan. 20, 2004).
- 66 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 8.22, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
- 67 *Id.* para. 8.21; *Beijing Declaration and Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, para. 107(i), U.N. Doc. DPI/1766/Wom (1996).
- 68 *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, U.N. GAOR, 21st Special Sess., New York, United States, June 30-July 2, 1999, para. 62(b), U.N. Doc. A/S-21/5/Add.1 (1999).
- 69 See Safe Motherhood Inter-Agency Group, *Safe Motherhood Fact Sheet: The Safe Motherhood Initiative*, *supra* note 19.
- 70 See WHO, *Making Pregnancy Safer Initiative: Document for Discussion 3* (on file with CRLP).
- 71 NILS DAULAIRE ET AL., GLOBAL HEALTH COUNCIL, PROMISES TO KEEP: THE TOLL OF UNINTENDED PREGNANCIES ON WOMEN'S LIVES IN THE DEVELOPING WORLD 7 (2002).
- 72 *Id.* at 8.
- 73 *Id.*