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REVIEW OF MATERNAL HEALTH POLICIES/STRATEGIES FROM A REPRODUCTIVE RIGHTS PERSPECTIVE

Focus on Maternal Health Policies/Strategies in Bangladesh, Cambodia, India, Indonesia, Lao PDR, Nepal, Pakistan, Papua New Guinea, Philippines, Solomon Islands and Timor-Leste

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Asia and the Pacific Regional Office
Bangkok, April 2010

Abbreviations

ADB	Asian Development Bank
CEDAW	Committee on the Elimination of Discrimination Against Women
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DC	Convention on the Rights of Persons with Disabilities
DHS	Demographic Health Survey
EmOC	Emergency Obstetric Care
GDP	Gross Domestic Product
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic, Social and Cultural Rights
ICERD	International Convention on the Elimination of Racial Discrimination
ICPD	International Conference on Population and Development
ICEDAW	International Convention on the Elimination of Discrimination Against Women
JSY	Janani Suraksha Yojana
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ration
MNCH	Maternal Neonatal and Child Health
MNCHN	Maternal Neonatal Child Health and Nutrition Programme
NRHM	National Rural Health Mission
NGOs	Non Governmental Organisations
PNG	Papua New Guinea
RCH	Reproductive and Child Health Programme
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Contents

	Executive Summary………………………………………………………..........…	1
I.	Background and context…………………………….................................	3
II.	Conceptual framework……………………………………………........…….	6
III.	The integration of reproductive rights in maternal health policies……....	8
	Formal recognition………………………………………………………..…….	8
	Availability of resources………………………………………...…………	11
	Combating discrimination, vulnerability and inequality…………….......…….	12
	Available, Accessible, Acceptable and Good Quality………………….........…..	14
	Participation…………………………………………………………………….	20
	Accountability……………………………………………………………..	21
IV.	Recommendations: Using human rights to fill the gaps	23
V.	Conclusion………………………………………........……………….	26

Appendix I……………………………………………………………………………….........27
Appendix II…………………………………………………………………………….......….28
Appendix III…..…………………………………………………………………........……….29
Notes……………………………………………………………………………......…………32

Executive Summary

Over half a million women die each year due to complications during pregnancy and child birth. 44% of these women die in the Asia and the Pacific. The vast majority of these deaths are preventable. At the Millennium Summit in 2000, States resolved to reduce maternal mortality by three quarters by the year 2015. This commitment is encapsulated in the Millennium Development Goals. Goal 5 is a commitment to improve maternal health: the reduction of maternal mortality is an outcome chosen to assess the progress in this regard. Halfway to the MDG target date it is clear that many Asian and Pacific countries that were reviewed will not meet Goal 5 unless action is taken now.

In recent years there has been an increased recognition of preventable maternal mortality and morbidity as a health, development and human rights challenge, which requires effective promotion and protection of human rights of women and girls, in particular their rights to life; to be equal in dignity; to education; to be free to seek, receive and impart information; to enjoy the benefits of scientific progress; to freedom from discrimination; and to enjoy the highest attainable standard of health, including sexual and reproductive health.

There is a strong consensus among health experts regarding effective interventions to address maternal mortality, these are generally easy to reach and are even cost-effective. Yet many women living in the eleven countries selected for the review do not benefit from them. The obstacles range from inadequate allocation of resources for maternal health services, severe health workforce crisis, unmet need for family planning, and lack of data and accountability mechanisms. This is a result of denial of reproductive rights of women and girls. Reproductive rights results in entitlements to the conditions, including access to health-care, that will enable them to affect their lives; and to demand accountability from the people and institutions that have the duty to take steps to fulfil those rights.

This paper reviews the extent to which relevant laws, policies and strategies are in place in the identified countries. Additionally, the paper reviews the extent to which these legal instruments have been translated into practical strategies and plans that have been implemented nationwide. The eleven countries selected for this review have high maternal mortality ratio. The methodology involved desk research of the maternal health polices/strategies and DHS data and reports by UNFPA, WHO, UNICEF, civil society organisations and others. The analysis does not try to be comprehensive, but rather indicative of broad trends. The focus of this paper is to briefly examine the extent to which policies and programmes launched by the selected countries to improve maternal health, integrate reproductive rights.

Preliminary findings of the research were presented at the Regional Consultation on Maternal Health and Rights in Bali, Indonesia, on 13-15 August 2009. Feedback from the country level and from participants at the workshop contributed to the finalisation of the paper and a more detailed and up-to-date understanding of how policies and programmes are working on the ground, and what kinds of recommendations and policy actions may be appropriate in order to consolidate existing gains and fill any identified gaps.

Key recommendations include:

- Focus on the disadvantaged and marginal: the average condition of the population can be misleading as improvements in population level health indicators can mask a deteriorating situation for some disadvantaged groups. Human rights require that, so far as practical, all relevant data are disaggregated on the prohibited grounds of discrimination. This helps in monitoring the situation of marginal groups, such as women living in poverty, indigenous people, minorities and so on.
- Effective Planning: from the perspective of human rights, effective planning is absolutely critical. This is one of the weakest features in countries with alarmingly high rates of maternal mortality. Health planning aimed at preventing and reducing maternal mortality is complex and includes many elements such as situational analysis, impact assessments, and inter-sectoral coordination.
- Strengthen health systems: Functioning health systems with an enabling environment that ensures adequate supplies, equipment, and infrastructure as well as an efficient and effective system of communication, referral, and transport are essential to averting the risks of maternal mortality.
- Resolve the health workforce crisis: human resources are in crisis in many health systems. In many resource poor countries, obstetricians are not available at every appropriate health facility. Governments should institute simple but safe standards of care that can be provided by well-trained physicians, nurses, and other personnel, taking into consideration overall human resource availability in country and population needs.
- International assistance and cooperation: States have the obligation to take steps individually and through international assistance and cooperation towards the full realisation of various rights, including the right to health. Depending upon the availability of resources, developed countries should provide financial and technical assistance to supplement the resources of developing countries with a view to preventing and reducing maternal mortality.
- Strengthen monitoring and accountability: Monitoring maternal deaths is essential in order to assess the scale of maternal mortality, its causes, and whether measures are being taken to address the problem. Registering maternal deaths is only the starting point; a human rights-based approach requires that the deaths are explained, through a careful evaluation of the factors that lead to maternal deaths.
- Looking beyond EmoC: one-size-fits all policy for reduction of maternal mortality does not work - maternal health policies/strategies need to be context-specific. Context specific services and community-based strategies, in addition to health centre intrapartum care, can reduce maternal mortality.

1 Background and Context

Every year more than half a million pregnant women die while giving birth. The situation is particularly acute in Asia and the Pacific, whose share of the global total of maternal deaths is more than 44%. Furthermore, the unmet need for family planning in Asia and the Pacific is 55%. Access to emergency obstetric care in the region is often inadequate. The main causes of maternal mortality in the region are haemorrhage, obstructed labour, sepsis, and unsafe abortion. The scale of this tragedy means that in Asia and the Pacific MDG 5 – on reducing maternal mortality and achieving universal access to reproductive health – simply cannot be achieved unless further action is taken.[1] States are obligated under international law to take all steps necessary to reduce stillbirth and maternal mortality, and to assure medical services to all in the event of sickness.[3] There are many human rights that, taken alone and in combination with others, serve safe motherhood. A human rights framework can remedy disadvantages that predispose women to vulnerability in pregnancy.[4] The Millennium Project Task Force on Child Health and Maternal Health is unequivocal in its recognition of the role of human rights, including the right to health, in policymaking to reduce maternal mortality.

Box 1: UN Human Rights Council Resolution on Maternal Mortality, 2009

"…most instances of maternal mortality are preventable, and that preventable maternal mortality is a health, development and human rights challenge that also requires the effective promotion and protection of human rights of women and girls, in particular their right to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health."[2]

All the countries selected for this review are committed to ICPD Programme of Action. A majority of these countries have either a stand alone policy on reproductive health or a reproductive health strategy that is a part of the population policy. Most of the countries have ratified majority of inter-national human right treaties recognising the right to health.

However, in spite of these commendable policies certain factors diminish the likelihood that these policies will enable significant progress to be made in reducing maternal mortality. These include:

- *Inadequate resources*

There are many factors behind the slow progress on maternal health indicators, such as lack of consensus on strategies, weak health systems and others. However, one of the biggest factors impacting maternal health is lack of resources allocated for health generally and maternal health in particular (see comparison between military and health expenditure in some South-Asian countries on the following page).

- *Health workforce crisis*

The majority of countries selected for the review are affected by a severe shortage of health workers. Life-saving care is often unavailable to women giving birth. Rural and disadvantaged areas are those most likely to be without a provider in public facilities.[5] There have been some efforts to strengthen human resources for the health sector, however, there

Box 2: Women have a right to lifesaving care

Governments are obliged to respect, protect and fulfil human rights related to universal access to health services that help prevent maternal health and injury:

- Women have the right to life (*ICCPR, article 6*).
- Women have the right to the highest attainable standard of health, as well as health services that are accessible, affordable, of good quality and acceptable (*ICESCR, article 12; CEDAW, article 12*).
- Women have the right to be free from discrimination on the grounds of sex, race, nationality, income or property, religion, health status, social origin and other status, including the provision of health services (*ICCPR, article 2*).
- Women have the right to enjoy the benefits of scientific progress, including in the area of emergency obstetric care (*ICESCR, article 15*).
- International assistance and cooperation must be part of the progressive realization of the right to health services in low-income countries (*ICESCR, article 2*).

Source: IIMMHR, No More Needless Deaths, 2009.

remains a large shortage of medical doctors, trained nurses and midwives whose availability is critical for the provision of maternal health care services.[6]

- *Unmet need for family planning*

Globally, one in three deaths related to pregnancy and childbirth could be avoided if all women had access to family planning services. A human rights-based approach to maternal mortality requires access to comprehensive family planning services.[7] Women and men have the right to informed about – and to have access to – safe, effective, affordable and acceptable methods of family planning of their choice. However, in many countries reviewed this is not the case. The unmet need for family planning ranges from 45.9% to around 25%.[8]

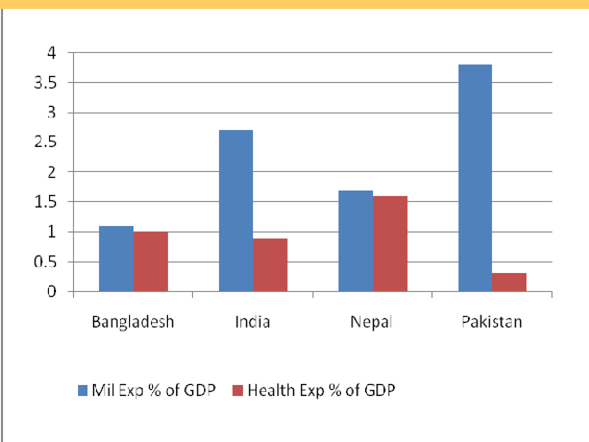
- *Cultural sensitivity*

A vast majority of women in the countries reviewed still continue to prefer home-based deliveries as compared to institutional deliveries. This is often in response to a lack of culturally sensitive care in health centres. However, there appears to be little in place in the policies to address this.

- *Underlying determinants*

A human rights-based approach to maternal mortality is not just about health care, but also includes an entitlement to other social, economic, cultural and political determinants of heath. The majority of these determinants have a direct influence on access to the health services that are essential for preventing and reducing maternal mortality. However, there is inadequate attention paid to these determinants in the policies and strategies aimed at reducing maternal mortality.

Military and Health Expenditure in Selected South Asian Countries



Country Background

Country	Total Population (millions) 2008	Total Fertility Rate 2008	Maternal Mortality Ratio*	Births per 1,000 women aged 15-19
Bangladesh	161.3	2.81	570	125
Cambodia	14.7	3.13	540	42
India	1186.2	2.78	450	62
Indonesia	234.3	2.16	420	40
Lao PDR	6.0	3.15	660	72
Nepal	28.8	3.24	830	115
Pakistan	167.0	3.46	320	36
Papua New Guinea	6.5	3.74	470	51
Philippines	89.7	3.20	230	47
Solomon Islands	0.5	4.6	220	…
Timor-Leste	1.2	6.48	380	…

- *Lack of data*

There are serious problems with respect to the availability, accessibility and quality of data on maternal deaths in the countries reviewed. Human rights require that, so far as practical, all relevant data are disaggregated on the prohibited grounds of discrimination, this helps in monitoring the situation of marginalized groups. The lack of reliable data makes it difficult to plan effective strategies to address maternal mortality. However, this important issue is not adequately addressed in policies and strategies aimed at decreasing maternal mortality.

- *Accountability*

A human rights-based approach to maternal mortality requires effective, accessible and transparent monitoring and accountability mechanisms. However, accountability mechanisms. However, general and specific monitoring and accountability mechanisms available and employed to uphold a human rights approach to maternal mortality in the selected countries are reportedly weak.

This paper reviews the extent to which relevant laws, policies and strategies are in place in the identified countries. Additionally, the paper reviews the extent to which these legal instruments have been translated into practical strategies and plans that have been implemented nationwide.

2 Conceptual Framework

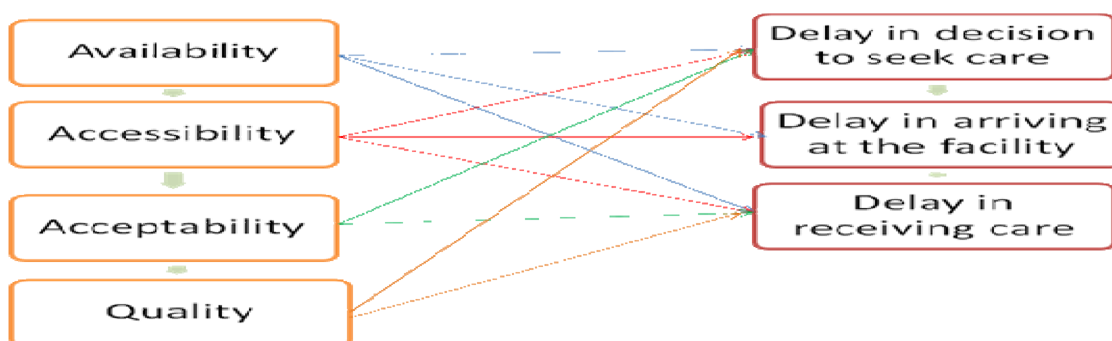
Reproductive rights in themselves are not new, but are a key element of long-established and internationally recognized human rights. However, the movement for human rights has focused more on the right to survival against oppression, than on the quality of life to which health is central. Maternal death has been accepted as part of the natural order, rather than an avoidable consequence of women's ill health resulting from unjust disadvantage.[10]

In recent years, there has been a deepening conceptual understanding of maternal mortality as a human rights issue.[11] Several human rights may be cumulatively and interactively applied to advance safe motherhood.[12] These include rights to life and personal liberty; right to health; right to non-discrimination; right to information and education (see Appendix II). This is not an exhaustive list but is indicative of the range of rights that may be applied to promote safe motherhood. While the discussion below looks at integration of reproductive rights generally in policies and strategies relating to maternal health, it particularly focuses on the right to health and, explores how this specific right has been or could be applied.

Box 3: ICPD Programme of Action, 1994

"*everyone has the right to the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health -care services, including those related to reproductive health care….*"[13]

Availability, accessibility, acceptability and quality of EmOC and the three delays model*



Source: Based on PHR, Deadly Delays, 2007, illustration of D Maine, Safe Motherhood Programs: Options and Issues, 1991.

* According to UNCESCR General Comment 14, *Availability* requires an adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services. *Accessibility* requires a) Maternal health and sexual and reproductive health services which are both physically and financially accessible; b) Health services must be accessible on the basis of non-discrimination; c) The right to seek, receive and impart information and ideas concerning health issues, including information that can help prevent maternal mortality. *Acceptability* requires that all health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements. *Good quality* requires that maternal health care services must be medically appropriate and good quality.

It has been well documented that maternal mortality is overwhelmingly due to three delays: in deciding to seek appropriate medical help for an obstetric emergency (e.g. for reasons of cost); reaching an appropriate facility (e.g. for reasons of distance); and receiving adequate care when a facility is reached (e.g. because there are shortages in staff). The "three delays" are interrelated. Reproductive rights encompass norms and obligations which are relevant in each of these contexts. If fulfilled, these norms and obligations would give rise to a reduction of maternal mortality.

The following framework draws on General Comment 14, the work of the UN Special Rapporteur on the right to health, WHO, UNFPA, civil society organizations, and others. Key elements of the framework are very briefly summarized as follows:

(a) Formal recognition: Maternal health related policies and strategies should explicitly recognise and integrate reproductive rights, including the right to the highest attainable standard of health;

(b) Available resources: According to ICESCR State parties should undertake steps to the maximum of their available resources for the progressive realization of the rights contained in the Covenant (which includes the right to health); [16]

(c) Combating discrimination, inequality and vulnerability: Issues of non-discrimination, equality and vulnerability require special attention. State parties should take steps to reach the excluded; [17]

(d) Available, Accessible, Acceptable and Good Quality: All health services, goods and facilities should be available, accessible, acceptable and of good quality;

(e) Participation: Individuals and communities should be given an opportunity to actively participate in decision-making that has a bearing on their health;

(f) Accountability: There should be effective, transparent and accessible monitoring and accountability mechanisms available at the national and international levels.

With a view to analyse the progress made in the reduction of maternal mortality, this paper will briefly apply some of the elements of this framework to policies and strategies relating to maternal health in the selected countries. As indicated at the outset however, this is *not* a comprehensive analysis of the realisation of reproductive rights or maternal health in these countries. Instead, the focus of this paper is to briefly examine the extent to which policies and programmes launched by the selected countries to improve maternal health integrate reproductive rights.

3 The Integration of Reproductive Rights in Maternal Health Policies

An equitable, well-resourced, accessible and integrated health system is widely accepted as a vital pre-condition for guaranteeing women's access to interventions that can prevent or treat causes of maternal death.[18] The following paragraphs analyse the integration of reproductive rights, which includes human rights such as the right to health in the policies and strategies aimed to enhance realisation of maternal health and reduce maternal mortality and morbidity.

Formal recognition

Maternal health related policies and strategies should explicitly recognise reproductive rights including the right to the highest attainable standard of health as well as integrate them at all stages, from development to implementation of a rights-based approach to maternal mortality. States should not only recognise these rights in national law, but also ensure that there are more detailed provisions clarifying what is needed by way of health-related services and facilities, including in relation to maternal health.

All the countries selected for this review are committed to the ICPD Programme of Action. While most of the countries have ratified the majority of international human right treaties recognising the right to health, only a couple of them, namely, Philippines and Timor-Leste recognise the right in their domestic constitutions. A majority of these countries have ratified the International Convention on Civil and Political Rights and all of them protect the right to life and non-discrimination in their national constitutions. Besides Nepal which contains a specific right of every women to reproductive health and other reproductive matters in the interim constitution,[19] no other constitution in the countries analysed contains a similar provision. In most of these countries abortion is only available to save a woman's life or is prohibited altogether.

Policies and Strategies

While most of the policies/strategies reviewed contain some reference to reproductive rights including the right to health, a human rights-based approach is often not systematically integrated.

- The Bangladesh National Strategy for Maternal Health includes a specific reference to the rights of women to safe motherhood and the programme of action is built around the 'three delays' framework of factors that hinder the women from receiving the services they require. Maternal mortality reduction is a priority objective for the Bangladesh Health Nutrition and Population Sector Programme, which includes measures to ensure that poor women have equitable access to quality safe motherhood services.[20] However, neither of these policies systematically integrates a human rights-based approach.

- The Health Sector Strategic Plan of Cambodia adopts a progressive approach and affirms equity and the right to health as values guiding the Plan. It recognises the need for sustainable development of the health sector responsive to peoples needs especially the poor, women and children although these rights are not systematically integrated in the Population Policy. The Government does however explicitly support client and provider rights, and is said to be developing and piloting a rights package. [21] The National Strategy for

Country	ICPD	ICCPR	ICESCR	CERD	CE-DAW	CRC	DC	National Constitution			Abortion Policies∞
								RTH	RTL	ND	
Bangla-desh	Y	Y	Y	Y	Y	Y	Y	×	√	√	E
Cambo-dia	Y	Y	Y	Y	Y	Y	Y*	×	√	√	A
India	Y	Y	Y	Y	Y	Y	Y	×	√	√	B
Indonesia	Y	Y	Y	Y	Y	Y	Y*	×	√	√	E
Lao PDR	Y	Y*	Y	Y	Y	Y	Y*	×	√	√	E
Nepal	Y	Y	Y	Y	Y	Y	Y*	×	√	√	A
Pakistan	Y	Y*	Y	Y	Y	Y	N	×	√	√	D
Papua New Guinea	Y	Y	N	Y	Y	Y	N	×	√	√	E
Philip-pines	Y	Y	Y	Y	Y	Y	Y	√	√	√	E
Solomon Islands	Y	N	Y	Y	Y	Y	N	×	√	√	E
Timor-Leste	Y	Y	Y	Y	Y	Y	N	√	√	√	E

Y=Ratified
Y*=Signed only
N=Not signed not ratified
RTH: Right to Health
RTL: Right to Life
ND: Non Discrimination
×: No
√: Yes

∞=based on categorisation developed by Centre for Reproductive Rights
A=without restriction as to reason
B=socioeconomic grounds
C=to preserve mental health
D=to preserve physical health
E=to save a women's life or prohibited altogether

- Reproductive and Sexual Health in Cambodia acknowledges human rights and empowerment as guiding principles but falls short of integrating them in a systematic manner. [22]

- The recently launched National Rural Health Mission in India seems not to adequately reflect human rights.[23] The Janani Suraksha Yojana (maternal health scheme under NRHM) aims to enhance the reduction of maternal mortality in India, yet it contains no reference to reproductive rights or the right to health or, it seems, a human rights-based approach to maternal mortality.[24] Similarly, in-spite of a categorical acknowledgement of the right to health by the working group on health of women and children, the 11th 5-year plan appears not to integrate reproductive rights or the right to health.[25]

- The National Development Program in Indonesia recognises the need to reduce maternal mortality as the main priority of health development. It affirms the need to enhance coverage, to improve the quality of reproductive health services, including family planning services.[26] However, the Program neither explicitly recognises reproductive rights nor does it integrate a human rights-based approach. On the other hand recognizing the need to improve

maternal and neonatal health, the of Indonesia has recently launched the Making Pregnancy Safer initiative with the following goals: protecting reproductive and human rights by reducing the burden of unnecessary illness, disability and death associated with pregnancy, childbirth and neonatal period. [27]

▪ Although the National Population and Development Policy of Laos claims to be informed by the commitments and Programme of Action adopted by the 1994 ICPD and by the MDGs, there is no reference to reproductive rights.[28]

▪ Similarly, the Nepal Second Long Term Health Plan, Health Sector Strategy, and Health Sector Strategy Plan all aim at improving health outcomes for the poor and those living in remote areas and a consequent reduction in poverty. Safe motherhood and neonatal health are key elements of the essential healthcare package. However, there is no reference to reproductive rights generally or the right to health in particular. [29] The National Reproductive Health Strategy Nepal aims to strengthen and expand basic maternity care services, including family planning, improved access, coverage and quality of overall reproductive health programme and recognises health as a basic human right. [30] The Strategy acknowledges that investments in and access to reproductive health, including family planning and sexual health, are essential in breaking the cycle of poverty. However, the strategy falls short of systematically integrating a human rights-based approach.

▪ The Government of Pakistan's commitment to improve maternal and child health is expressed through a number of interventions, such as the Maternal and Newborn Child Health Program. The overall vision of the Program is to ensure "health for all" with attention directed towards the primary and secondary levels of the health care system coupled with community outreach services through integrated system-wide approaches. [31] Further, although there are some brief references to human rights in the Policy it falls short of systematically integrating them.[32]

▪ Similarly, while the Philippines Reproductive Health Policy recognises commitment to reproductive health rights as a key aspect of the Policy, these rights are not integrated in the policy as such.[33] The Reproductive Heath Bill aimed at providing access to contraceptives has been languishing in the Parliament for almost two decades now.

▪ In the Global Survey conducted by UNFPA, Pacific Island Countries were asked if they had taken any policy measures, legislative/institutional changes or other national level measures to enforce reproductive rights (such as free informed choice and informed consent, abolition of quotas, incentives, etc). Ten of the thirteen countries (including PNG and Solomon Islands) responded affirmatively whilst three countries reported not taking any measures to enforce reproductive rights.[34] Several countries, including PNG and Solomon Islands reported the formulation of new policies on reproductive rights and reproductive health. In the Solomon Islands, Women and Youth Policies developed two years ago incorporated reproductive rights. In PNG, policy changes have included the provision of free family planning, antenatal and delivery services in an attempt to improve access and utilisation.

▪ According to the National Reproductive Health Strategy in Timor-Leste, the Government subscribes to the principles enunciated in the Programme of Action agreed upon at the International Conference on Population and Development. In particular the Government endorses Principle 8 of the ICPD Programme of Action. Although there is a reference to reproductive rights, these rights are not, however, systematically integrated in the Policy. [36]

Box 4: Philippines RH Bill

In the year 2000, Manila City declared a ban on contraception, under Executive Order 003. The Order prohibits Manila City women - especially poor women - from accessing all forms of modern contraceptives, condoms, and information necessary to protect their reproductive health. As a result, women are unable to prevent pregnancy, even when it would jeopardize their lives, health, or ability to feed their families.

The ban is in violation of the Philippines government's international legal obligations. Philippines has ratified a number of international human rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women, that clearly recognize a woman's fundamental right to family planning services and information - a right that underpins a host of other key human rights, including the right to decide the number and spacing of one's children, the right to life, the right to health, the right to equality, and the right to be free from discrimination.

The Reproductive Health Bill currently being considered by the lawmakers in Philippines has stirred up significant debate over its potential to promote economic development and improve access to healthcare, particularly reproductive healthcare. The Reproductive Health Bill is also essential to remedy egregious violations on Filipino women's international and national legal rights resulting due to ban on contraceptives. [37]

Availability of resources

According to article 2(1) International Convention on Economic, Social and Cultural Rights (ICESCR) States are required to take immediate and progressive steps to achieve rights enshrined in the Covenant which includes 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."[38]

Country	Health expenditure per capita (current US$)	Health expenditure, public (% of GDP)
Bangladesh	12	1
Cambodia	30	1.5
India	29	0.9
Indonesia	39	1.3
Lao PDR	24	0.7
Nepal	17	1.6
Pakistan	16	0.3
Philippines	52	1.3
PNG	29	2.6
Solomon Islands	44	4.7
Timor-Leste	52	15.2

A World Bank study confirms that family planning and maternal health services are the most cost-effective governmental health interventions in terms of death and disability prevented.[39] When a mother dies, according to the study 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. [40]

Yet, the amount of money spent by the governments on health is extremely low, and the proportion spent on maternal health is even lower.

- In Cambodia for instance, the poor health indicators reflect the country's conflict scarred past. 30 years on, the Government's efforts to rebuild health infrastructure and improve health systems are seriously hampered by a low national health budget. There has been a decline in percentage of GDP allocated to health over the years. [42] The bulk of this money goes towards paying staff salaries while the widely accepted practice of "unofficial user fee" for public health facilities further disadvantages the poor.[43] Under the National Strategy for Reproductive and Sexual Health a priority expressed by the Government, is to generate sufficient funds to support key reproductive and

Box 5: Why invest in maternal, newborn and child health?

According to a joint study conducted by the ADB, UNFPA, UNICEF, World Bank and others there are five reasons why governments from both developed and developing countries should invest more in the health of women, mothers and their children.

1.Women's and children's health is valuable in itself.

2.There are proven and affordable ways of saving lives of women and children.

3.Investing in maternal, newborn and child health makes economic sense.

4.Investing in maternal, newborn and child health has political benefits, including social stability and human security.

5.Investing in maternal, newborn and child heath makes the health system work better. [41]

government intends to increase total and per capita reproductive health expenditure by 25% beginning with a minimum of a 10% increase in 2006.[44] The information to verify whether this increase has actually taken place is not available.

■ Lack of resources for health impacts negatively on the health sector in India as well. The public health investment in the country over the years has been comparatively low and as a percentage of GDP is only 0.9 percent. [45] The Committee on Economic, Social and Cultural Rights (CESCR) has recently expressed its concern that despite the economic growth achieved by India, health care expenditure was low, and a significant proportion of the population continues to have limited or no access to basic health services.[46] Similarly the UN Committee on the Elimination of Add Forms of Discrimination Against Women, while expressing concern on the high rates of maternal mortality in India, called on the Government to adopt a holistic approach to women's health and allocate resources from a "women's right to health" perspective.[47] In recent years, however, there has been an increased focus on maternal mortality in India. The Government, for instance, promises to increase allocation of health to 2-3 % of GDP. [48]

■ The situation in Laos and Pakistan are of particular concern. The proportion of GDP spent on health in Laos is 0.7% and in Pakistan, only 0.3%, which are amongst the lowest in the region. Due to poor investment in health care, salaries for health workers are unacceptably low and the budget provided to health facilities is insufficient to cover all expenses required for service provision. [49] In an acknowledgement of the seriousness of the situation the Government of Pakistan under the Mid Term Budgetary Framework, aims at enhancing allocation to the health sector with an average annual increase of 16 per cent. The preventive share in the total allocation is being enhanced from less than 55 per cent at present to about 65 per cent over the next few years through a rolling plan. The MTBF approach will be extended to provincial health departments. [50]

■ Implementing new strategies continues to be a challenge in resource-constrained settings of PNG and Solomon Islands where small populations are widely dispersed. [51] The health sector appears to be one of the biggest losers in the 2009 Budget in PNG. Although the Government injected some K46 million of recurrent funds for hospital management services, this was offset by a reduction of 17 percent in funding for the Department of Health, to K131 million. Similarly, the national government in Solomon Islands has cut provincial health budget by 35% after first quarter of 2009, despite increasing health service demands, in light of the global financial crisis.[52]

<u>Combating discrimination, inequality and vulnerability</u>

The low status of women and girls, poor access to information and care, early age of marriage and restricted mobility are factors that contribute to maternal mortality. [53] Gender equality and empowerment lead to greater demand by women for family planning services, antenatal care and safe delivery, which play an important role in preventing maternal mortality. [54]

Box 6: CEDAW on Maternal Health in the Selected Countries

Cambodia (CEDAW/C/KHM/CO/3)

Para 29

The Committee notes that despite the reduction in the rate of maternal mortality, the number nevertheless remains high at 417 deaths per 100,000 live births, owing primarily to lack of access to obstetric emergency services. The Committee is also concerned that only 10 per cent of births takes place in a health facility.

Para 30

The Committee recommends that the obstacles to accessing obstetric services be monitored and removed and that (a) a strategic plan to reduce maternal mortality and morbidity be put in place through which quality prenatal, post-natal and emergency obstetric services are progressively distributed in all provinces; (b) a proactive referral service be established to facilitate access to obstetric services; (c) benchmarks be set for the reduction of maternal mortality; and (d) the necessary funding be specifically mobilized from all sources.

India (CEDAW/C/IND/CO/3)

Para 40

The Committee continues to be concerned about the status of women's health, including the maternal mortality rate in rural areas, which is among the highest in the world; the high prevalence of infectious diseases, especially food and waterborne diseases; malnutrition; anaemia; unsafe abortions; HIV infections; and inadequacy of services relating to obstetrics and family planning. While noting the programmes outlined in the report to improve women's access to health care and to decrease maternal mortality, the Committee is concerned that it has not been provided information about the impact of such programmes and measures. It is also concerned that the State party lacks reliable data on women's health status, including on pregnancy and non-pregnancy-related morbidity and mortality and HIV infections, owing to which it is unable to establish benchmarks and monitor progress. In addition, the Committee is concerned that the privatization of health services has an adverse impact on women's capacity to access such services.

Para 41

The Committee urges the State party to pay increased attention to female health throughout the life cycle, including in key areas of pregnancy and non-pregnancy-related morbidity and mortality, in light of general recommendations 24 and 25. It calls upon the State party to strengthen food security, primary health care and adequate sanitation, especially in rural areas; establish mechanisms to monitor women's access to health care and health delivery systems; and increase the allocation of resources to health care. The Committee urges the State party to prioritize decreasing maternal mortality rates by establishing adequate obstetric delivery services and ensuring women access to health services, including safe abortion and gender-sensitive comprehensive contraceptive services. It recommends that the State party provide detailed information in its next periodic report about the impact, and trends over time, of programmes to improve women's access to health care and decrease maternal mortality. It calls upon the State party to balance the roles of public and private health providers in order to maximize resources and the reach of health services. It calls upon the State party to monitor the privatization of health care and its impact on the health of poor women and provide such information in its next periodic report.

Philippines (CEDAW/C/PHI/CO/6)

Para 27

The Committee expresses its concern about the inadequate recognition and protection of the reproductive health and rights of women in the Philippines. The Committee is concerned at the high maternal mortality rates, particularly the number of deaths resulting from induced abortions, high fertility rates, inadequate family planning services, the low rates of contraceptive use and the difficulties of obtaining contraceptives. It is also concerned about the lack of sex education, especially in rural areas. It is concerned at the high rate of teenage pregnancies, which present a significant obstacle to girls' educational opportunities and economic empowerment.

Para 28

The Committee urges the State party to take concrete measures to enhance women's access to health care, in particular to sexual and reproductive health services, in accordance with article 12 of the Convention and the Committee's general recommendation 24 on women and health. It requests the State party to strengthen measures aimed at the prevention of unwanted pregnancies, including by making a comprehensive range of contraceptives more widely available and without any restriction and by increasing knowledge and awareness about family planning. The Committee recommends that the State party give priority attention to the situation of adolescents and that it provide sex education, targeted at girls and boys, with special attention to the prevention of early pregnancies and sexually transmitted diseases. The Committee recommends that the State party consider reviewing the laws relating to abortion with a view to removing punitive provisions imposed on women who have abortions and provide them with access to quality services for the management of complications arising from unsafe abortions and to reduce women's maternal mortality rates in accordance with the Committee's general recommendation 24 on women and health and the Beijing Declaration and Platform for Action.

Arising from the concepts of non-discrimination and equality, international human rights law has a preoccupation with vulnerability and disadvantage. This requires a State to take measures in favour of disadvantaged communities, individuals and populations. In the present context, non-discrimination and equality have numerous implications. For instance, they require action to prioritise efforts towards those at particular risk of maternal mortality, such as women living in poverty and in rural areas or those belonging to indigenous groups, and adolescent girls.[55]

However, this is often not the case and the policies/strategies examined often seem to fall short of addressing this crucial issue.

- The CESCR in its concluding observations on India expressed a deep concern about the fact that in spite of constitutional guarantees of non-discrimination, widespread discrimination persists in India.[56] Similar concerns were noted by the UN Committee on the Elimination of All Forms of Racial Discrimination, which remarked that health care facilities are either unavailable in tribal areas or substantially worse than non-tribal areas.[57] According to the Citizen's Report, while the national average of maternal mortality is around 5 per 1,000, for nomadic people it is 10 per 1,000.[58] Further, the report stated that the unmet need for contraceptives amongst Muslims in India is higher than amongst non-Muslims.[59]

- Nepal guarantees equality and non-discrimination as fundamental rights under the interim constitution. However, it is reported that in rural areas family members do not often take immediate action to get the woman to hospital. The low status of the daughter-in-law in Nepalese culture and cash problems lead to the delay. According to the DHS almost half (48%) of children in urban areas are born in a health facility, compared with 14% in rural areas.[60] Although the National Reproductive Health Strategy talks about equitable access to quality health services with greater attention to poor,[61] it is reported that Nepal's rural poor and Dalit, Janjati women receive far lower levels of maternal health service coverage than other women.[62] However, the maternal health related policies do not address these concerns adequately.

- According to the Health Policy Framework of Timor-Leste the main thrust of the government is to increase access to services by making primary health care available and affordable to people of Timor-Leste, particularly vulnerable groups.[63] However, according to the MICS variation across strata was between rural and urban and highland and lowland areas (with rural and upland areas being worse off) supporting a view that isolation and difficulty of access to modern health facilities or personnel is a significant constraint in maternal health service delivery. Access is particularly constrained in highland areas where only about 12% of women had a trained attendant at birth, as well as in rural areas generally.[64]

<u>Available, Accessible, Acceptable and Good Quality</u>

Available

States should do all they can to ensure that maternal health care services are *available* to everyone in their jurisdiction.[65] According to the *UN Guidelines for Monitoring the Availability and Use of Obstetric Services (UN Guidelines)*, for a population of 500,000 there should be a minimum of four facilities offering basic EmOC and one facility offering comprehensive EmOC.[66] There is clear evidence that if obstetric services as suggested by the *UN Guidelines* are equitably distributed across the population it leads to a better capacity to address problems of maternal mortality. [67]

Even though several policies which were analysed make clear provision for *availability* of these services, in reality there seem to be gaps in implementation.

- For instance, the National Strategy for Reproductive and Sexual Health of Cambodia acknowledges service availability as a

Country	Unmet need for family planning (%)	Births with skilled attendants (%)
Bangladesh	11.3	20
Cambodia	25.1	44
India	12.8	47
Indonesia	9.1	66
Lao PDR	27.3	19
Nepal	24.6	19
Pakistan	30.0	54
Philippines	17.3	60
PNG	45.9	38
Solomon Islands	11.1	86
Timor-Leste	3.8	19

key barrier,[68] as there is a severe health workforce crisis, whereby there is a concentration of health workers in urban areas.[69] As a result, a large majority of births (78 percent) were delivered at home, with only 22 percent being delivered in a health facility.[70]

■ The situation in India is no different. In 1992, India launched the Child Survival and Safe Motherhood programme followed in 1997 by a five-year programme called Reproductive and Child Health-I. Although EmOC was one of the strategies, the programme was not implemented.[71] Unavailability of qualified health workers is a major constraint for providing locally accessible skilled delivery care for rural women.[72] Only 30.7% of births in rural areas are attended by skilled birth attendants.[73] While schemes such as JSY have led to a tremendous increase in demand for institutional deliveries the main challenge is to ensure matching supply (in terms of well functioning facilities).[74]

■ The 2009 Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services identifies insufficient health system capacity as one of the biggest constraints in Laos achieving the MDGs.[75] According to the Strategy the health system has insufficient capacity to deliver key maternal, neo-natal and child health interventions. There has been insufficient investment in health and health workforce.[76] While the Reproductive Health Strategy of 2005 calls for availability and sustainability of, and access to quality family planning services to all couples of reproductive age, the unmet need for family planning services in Laos is 27.3%.[77] Surveys indicate that due to poor organization of care, opportunities for providing the full set of recommended maternal, neonatal and child health interventions are often missed. [78]

■ The Maternal and Newborn Child Health Program in Pakistan identifies availability of EmOC facilities as a key strategy for implementation of the Program. According to the Policy, a majority of maternal deaths could be avoided by ensuring prenatal and postnatal care and availability of EmOC services within reasonable distance.[79] However, lack of emergency obstetric care and 24/7 services – particularly in the rural areas – continues to impede achieving maternal health outcomes

in Pakistan. There is both a dearth of, and inefficient and inequitable deployment of health care providers who are often inadequately trained in EmOC.[80]

- According to the Philippines MNCHN Strategy improvements in health service delivery is identified as a key strategic area to rapidly reduce maternal mortality. The MNCHN aims to make available basic and emergency obstetric care services and public health services to reduce the risk of dying and improve the well-being of women, mothers and their children. Similarly, the Reproductive Health Policy 2000 establishes universal access to quality of reproductive heath care as its central goal. However, according to the DHS survey, only 38 % of live births in the five years preceding the survey were delivered in a health facility, whilst 61 percent were born at home.[81] Moreover, while 60% births are attended by skilled attendants, there were still 40% of births that were attended by traditional birth attendants, many of them untrained.[82]

- In its National Reproductive Health Policy the Government of Timor-Leste recognises the importance of availability of good-quality basic and comprehensive essential services to all women during pregnancy and childbirth to reduce levels of maternal and neo-natal mortality and morbidity in the country. However, according to the DHS 2003, in Timor-Leste 90% deliveries are home deliveries and skilled birth attendance is only 19%. Further, according to a recent study, due to the illegality of the practice, women in Timor-Leste are dying as a result of unsafe abortions. [83] According to the report: induced abortion occurs in Timor-Leste and is performed in clandestine ways which increases the health risks and compromises safety and policies and protocols reviewed did not give enough emphasis to the termination of pregnancy and unsafe abortion as a public health issue.

Accessible

In addition to being *available*, maternal health services should also be *accessible* to everyone without discrimination. In the context of maternal health services, access has four dimensions: safe physical accessibility; economic accessibility (i.e, affordability) including to those living in poverty; accessibility without discrimination; and information accessibility. Lack of access on any of these grounds can increase delays. For example, poor roads and infrastructure can lead to delay in arrival at a health facility. Similarly, high costs of health care services render services unaffordable. Lack of information about the warning signs for obstetric emergencies can also lead to delay in seeking care.[84]

There are many initiatives underway to ensure accessibility of maternal health services.

- The Government of Bangladesh has implemented several strategies to increase awareness about family planning and safe motherhood and has paid dividends as evident from the increase in knowledge levels. However, there are still information gaps on key issues such as the awareness about danger signs during pregnancy and birth preparedness plan, critical for overcoming the delay in seeking care and delay in reaching a health care facility.[85] Further, there are continuing disparities in access to maternal health services by income status, with women belonging to the lower economic quintiles having poor access to reproductive health care especially EmOC. Poorer, less educated women are less likely to seek qualified routine or emergency obstetric care. Only 40% of women who perceived that they had life threatening complications during their pregnancy sought immediate care – 70% of women in the highest wealthy fifth of the population and 50% of those in the lowest fifth.[86] Cost therefore continues to be a major barrier to accessing the public sector services.[87]

■ Under the Health Sector Strategic Plan Cambodia has identified priority policies in the following two areas: expansion of health facilities to effectively reach the poor and under serviced in rural areas; provision of maternal health services, including births spacing, ante and postnatal care, safe deliveries and emergency obstetric care, safe abortions and post-abortion counselling.[88] However, according to the DHS report 89 percent of women reported having one or more problems in accessing health care for themselves. The main problem in accessing health care was not having money for treatment (74%). Half of women were concerned that there would be no drugs or no health provider available at the health facility. 45 percent of women reported that they did not want to go alone to the health facility. Women in the 15-19 year age group cited problems in getting permission to go to a health facility (29%) and not wanting to go to the facility alone (66%). As expected, rural women were twice as likely to have problems related to distance to the health facility and need for transportation as urban women.[89] Young Cambodian women with higher incomes are increasingly utilising trained providers, while older and lower-income women often use TBAs. However, these women indicated they would also prefer a skilled provider, if one were more affordable and closer to home.[90]

■ The Cambodian government has developed the National Strategic Framework for Equity Funds and National Equity Fund Implementation & Monitoring Framework (May 2005) to reduce the impact of significant unexpected health costs on the poor. Equity funding will support pre-identification of women at risk, delivery of safe motherhood services (at home or facility), treatment fees, and transport and food costs for referral hospital level.[91]

■ The accessibility concerns in India are not much different. According to the National Family Health Survey-III, 26.3 % of women in India chose not to deliver at the health facility because they thought that it was too expensive and 11 % did not deliver at the health facility because it was either too far or there was no transport available.[92] Almost 6% of women did not use the health facility because either the husband or the family did not allow them to use such a facility.[93] Even though the JSY scheme makes provision for providing referral transport for pregnant mothers, it falls short of addressing other accessibility concerns such as discrimination and information.[94] The NRHM does not address the issues regarding lack of access due to denial of consent by husband or family, or issues regarding sexual and reproductive health information.[95] In a positive move, the 11th 5-year Plan acknowledges gender bias and the discrimination faced by women in accessing health care facilities and calls for special measures for gender empowerment and equity.[96]

■ In Laos the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services calls for facility based services and good referral systems to be ensured with reliable means of communication by radio or mobile phones and reliable transport for emergencies, complications and for difficult cases.[97] However, there is inadequate access and under-utlization of MNCH service in Laos.[98] Currently 89% of rural women deliver without a trained attendant, and most live a long distance from any services.[99] Further, many Lao women lack information on reproductive health, safe motherhood and modern contraceptive methods. There are also a large number of cultural factors that influence women's health Laos, which are not given adequate attention in the policy documents.[100]

■ Similar, issues impair access in Nepal. Access to health services in Nepal is limited due to remote mountainous areas, poor infrastructure, lack of sufficient and qualified health personnel, and socio-cultural and language barriers especially among excluded groups. The conflict had a serious impact on health services delivery.

Women's lack of access to health care, information and education contributed to high levels of female mortality and morbidity.[101] The National Reproductive Health Strategy makes a strategic objective to reduce distance in accessing obstetric care services. The Strategy also talks about provision for telephone and transport services for referrals.[102] However, deliveries at health facilities continue to be significantly lower among the lowest wealth quintile (4 percent) compared with 55% of births in the highest quintile.[103] According to a recent survey, the vast majority of women (73%) believed that it was not necessary to give birth in a health facility; 17% mentioned that it was not customary, 10% said that it cost too much, and 9% cited that a health facility was too far or that there was no transportation to a health facility.[104]

- Pakistan's National Health Policy emphasizes the need to improve quality and accessibility of maternal health services, particularly in the rural areas. All national programs on primary health care have included maternal health as a core component. The country's first maternal and child health program was launched in the early 1950s. In the 1990s, the Lady Health Worker program was introduced, which has a major emphasis on maternal health.[105] In spite of these efforts, progress in maternal health indicators has remained slow in comparison with other health and population indicators. Delays in seeking medical care for obstetric complications are common.[106] The MNCH Programme tries to address these concerns and emphasises the need for referral and transport of obstetric patients. The Programme proposes alternate transport mechanism such as ambulance services in the public sector; community transport mechanisms; utilization of NGO ambulances and CMW's reimbursement of transport expenses. [107] The importance of correct knowledge, attitudes and behaviours at the household and community levels besides essential heath services is emphasised as being of immense importance.[108]

- The MNCHN Strategy in the Philippines calls for mobilization of the service delivery network to deliver the integrated MNCH services as a continuum. Universal access to and utilization of integrated MNCH services in its full continuum spanning the pre-pregnancy, pregnancy, delivery of post-partum care phases according to the Strategy shall be ensured in all localities and shall be backed up by pertinent laws and accessible operational resources. The MNCHN Strategy further calls upon the government to develop schemes to support local health systems in designing, implementing and evaluating appropriate demand side interventions to improve health seeking behaviour and service utilisation in localities. Further, the Reproductive Health Policy 2000 recognises the need to raise awareness among Filipinos on reproductive health issues.

- However, according to the population and reproductive health survey conducted by UNFPA in Philippines one of the major problems identified was poor access to quality, culturally and gender-sensitive, and rights-based RH information and services, especially among the marginalized and disadvantaged. Around 75% of the poorest quintile did not have access to skilled birth attendants compared to only 20% of the richest quintile.[112] The unmet need for family planning in Philippines is 17.3%.[113] Survey findings, further, reveal that Filipino women across all socio-economic classes desire fewer children and would like to use modern contraceptives. Yet only about half of women of reproductive age practice family planning. Even when family planning services are available, it has been observed that the decision to seek health services is often determined by gender norms in the family and community, as well as cultural and religious beliefs and practices.[114]

- In Timor-Leste the National Reproductive Health Strategy guarantees that all pregnant women, whatever the circumstances of their pregnancy and delivery, will have access to

basic and comprehensive maternity care, comprising quality antenatal care, clean and safe delivery and postpartum care including newborn care free of charge.[115] However, the socioeconomic situation does not favour women's health, despite the fact that the Government has made maternal mortality reduction one of its specific goals. Further, low use of contraceptive methods leads to many unwanted pregnancies, the practice of unsafe abortion is an increasing health risk. Inadequate knowledge about contraception within Timor-Leste is an aggravating factor. According to the 2003 DHS, only one in three women was aware of at least one method of family planning and only 30% of men surveyed were aware that family planning methods exist.[116] Providing the Timorese with the knowledge and access to necessary to plan their families could lower the incidence of unsafe abortions.

Acceptable

As well as being *available* and *accessible*, maternal health facilities should be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements.[117] Lack of culturally *acceptable* health care facilities influences the decision of women to seek care, and can also lead to delays in receiving appropriate treatment at a health facility. Language barriers, for instance, can delay treatment at the facility. [118]

However, often these concerns are not adequately addressed in policies/strategies aimed at addressing maternal health.

- For instance, according to a recent review in Bangladesh, maintenance of privacy in clinics and labour rooms is not satisfactory. Patients according to the survey, are often not provided opportunities to express their concerns, which is critical for improving services.[119] The Bangladesh National Strategy for Maternal Health falls short of addressing these issues.

- The interventions launched by the Government of India do not appear to be adequately focused on making health care facilities culturally acceptable. Though the NRHM sets out a broad framework of interventions to reduce maternal mortality, the focus of the Government's interventions seems to be on increasing demand for institutional deliveries and the supply side interventions which are not systematically prioritised. Further, while highlighting the training needs of health care workers under RCH-II, there is no reference to training on cultural sensitivity.[120]

- Similarly, studies have shown that local traditions in Laos may prevent women presenting to health facilities at the onset of labour. Women also feel uncomfortable being seen by male health workers. There are difficulties for ethnic groups in accessing health services where often Lao language is spoken, rather than ethnic languages, and cultural differences are poorly managed.[121] The maternal mortality rate in Laos is higher in the remote areas where many inhabitants are ethnic populations. They have poor access to health services due to distance, linguistic barriers as well as economic constraints.[122] However, these concerns are not adequately addressed in the Reproductive Health Policies.

- This is reflected in Pakistan as well. According to local health staff one of the main problem is lack of female health workers at district level, coupled with poor awareness and misinformation amongst the population at large.[123] The MNCH Programme does not pay adequate attention to cultural aspects.[124] In recent years, the health sector has witnessed a major drive to increase the number of lady health workers but the remote and under-developed districts have not uniformly benefited from this due to non-availability of qualified women.[125]

- In the Philippines, because of cultural reasons, only natural family planning methods are allowed. Condoms, pills and other contraception are equated with

abortion, which is illegal and are therefore not available. House Bill 5043, known as the Reproductive Health Bill, advocates a comprehensive range of programmes and services addressing sexual and reproductive health, including education and universal access to both traditional and modern family planning services. For years the Bill has been stuck in the Parliament preventing women, especially in lower income groups, from obtaining reproductive health information and services.[126]

Good quality

Maternal health services and facilities must be of *good quality*; health workers must be polite and respectful. According to CESCR, "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."[127] Poor quality of care at health facilities can lead to reluctance to seek care at a health facility and contribute to high incidence of maternal mortality.[128]

In spite of repeated acknowledgements by governments of the need to strengthen the quality of healthcare services, healthcare services in the region continue to be of inadequate quality.

- According to the Laos MDG report many people are discouraged from using services because of low quality of care and unavailability of commodities.[129] This is acknowledged in the Reproductive Health Policy which emphasises the need for strengthening the health system for reproductive health. The quality and access to maternal care and other reproductive health services generally reflect the state of health of the country according to the Policy. Embracing a reproductive health approach therefore does not only require adding services and information but also integrating and ensuring delivery of these services at the individual, family and community levels.[130]

- In Solomon Islands according to a recent study of health seeking behaviour, one of the barriers preventing access to health care was identified to be the poor attitude of staff towards patients. The survey commented that work ethics and staff performances need to be seriously improved if a patient centred approach to improving health care is to work. However, these issues are not adequately addressed in relevant health policies.[131]

- The National Reproductive Health Strategy in Timor-Leste recognises the need to improve quality and coverage of prenatal, delivery, postnatal and perinatal health care. It further emphasises the need to improve emergency obstetric care through recognition, early detection and management or referral of complications of pregnancy and delivery.[133]

Participation

All individuals and communities are entitled to active and informed participation on issues relating to their health. This entitlement applies to all stages of a policy or programme cycle: assessment, analysis, implementation, monitoring and evaluation.[134] Human rights require that special efforts be made to ensure the participation of individuals and groups that have traditionally been excluded or marginalized, such as people living in poverty, women and adolescent girls. Some women, even though they are educationally and instrumentally "empowered", are not really in-charge of their own fertility; their societies and cultures are.[135] Participation by women therefore is particularly important because it helps elevate their position from passive clients to active citizens that are working together with policy makers and service providers.[136] However, this is often not the case.

Participation issues generally or those related to participation of women are often not adequately addressed. However, there is a growing acknowledgment that this needs to change.

services. As of August 2007, around 49,000 FCHVs nationwide have played great role in health promotion activities, including maternal child health care, family planning, immunisation, treatment of acute respiratory infection cases and referral to health facilities in districts, serving as frontline local health resource persons and the bridge between government health programmes and the communities. [139]

- The MNCHN Strategy in the Philippines calls for the engagement of local stake-holders to review the current functionality of their respective local service delivery networks.[140] The Reproductive Health Policy of Philippines emphasises the need to create an environment for participation of stakeholders in the health sector, and provide them with high quality care by considering their perspective in the selection and delivery of services. [141]

- In Solomon Islands the process of developing the National Health Strategic Plan has been a commendable one of widespread consultation and collaboration, participatory in approach and paced in a manner to ensure that all stakeholders feel they have made a valuable contribution to and are part of the process. It is a plan made by Solomon Islands people, for Solomon Islands people.[142]

- Similarly, in Timor-Leste the Health Policy Framework envisages developing community level involvement in health programme management as part of the strategic decentralization strategy. These will centre on establishing inter-sectoral collaboration and working through local communities to search for new ways to plan and implement health programmes in coordination with the Ministry of Health. More and more the provision of health care services will involve the other sectors as well as the community.[143]

Accountability

A human rights-based approach to maternal mortality requires effective, accessible and transparent monitoring and accountability mechanisms. For example, the registration of all maternal deaths is essential, as well as a procedure for investigating the causes of all such deaths. Often known as maternal death reviews or audits, the investigation must go beyond a narrow consideration of medical causes and review all circumstances, *including* relevant social, economic and cultural factors. Accountability in the context of maternal mortality provides individuals and communities with an opportunity to understand how those with responsibilities have discharged their duties. Equally, it provides those with responsibilities the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. But accountability is not necessarily a matter of blame and punishment.[144] It is a process that helps to identify what works, so it can be replicated, and what does not, so it can be revised.

However issues of accountability and governance are often not adequately addressed.

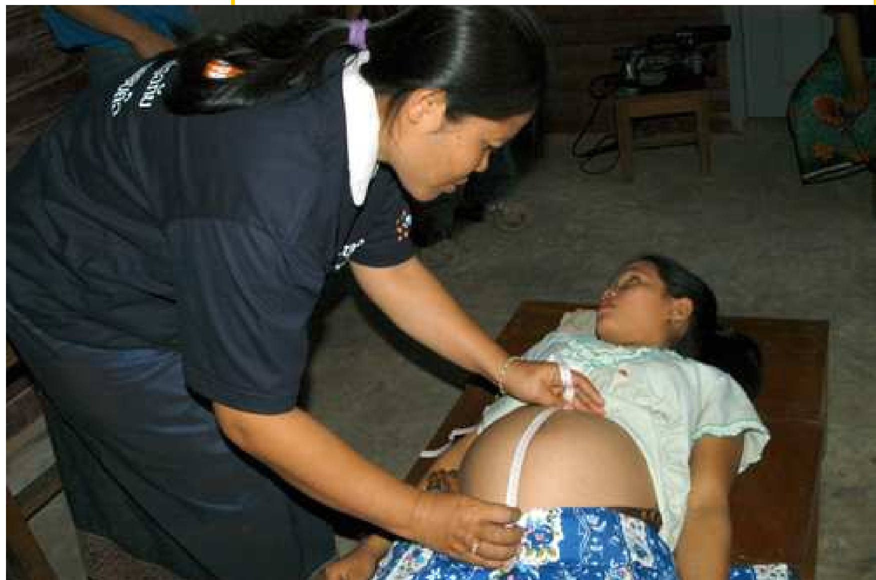
- According to a World Bank review for instance, in Bangladesh there is very little outreach to the community and virtually no accountability to clients.[145] Public health services in Bangladesh are hampered by governance and accountability problems, which are not duly addressed in the Bangladesh National Strategy for Maternal Health.

- In Cambodia, accountability, efficiency, quality and equity are said to be at the centre of the Second Health Sector Strategic Plan framework.[146] Good governance and accountability are identified as the working principles for the health strategic plan.[147] Information on the extent to which accountability mechanisms are in place and functioning was not available.

- While India has three main systems for measuring general mortality,[148] none of these is completely reliable for reporting maternal deaths. This means that data on maternal mortality and its causes appears to remain seriously flawed.[149] The Registrar General of India's report on maternal mortality notes that "naturalness" associated with maternal deaths, whereby it is considered "natural" that women die while giving birth, means that families and health workers often fail to report them, and they do not lead to a public outcry. Completeness of death reporting is decreasing among women, and is lower among women than men, suggesting that gender prejudice is influential.[150] Under the NRHM, NGOs are to be involved in crafting community monitoring systems and participatory monitoring committees.[151]

- In Laos, according to governments own assessment, strengthening leadership and management structures is necessary to ensure progress in maternal, neo-natal and child morbidity reduction.[152] There are gaps in availability of national standards, protocols and guidelines, implementation of government policies and guidelines and MCH staff capacity for program management particularly at provincial and district levels. Further, there is weak capacity in data collection, analysis and reporting and weak birth and death registration system particularly for still births and neo-natal deaths.[153] Improving leadership, governance and management capacity for programme implementation is identified as a key strategic objective in the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services.[154]

- The MNCHN Strategy of Philippines calls for the establishment of governance mechanisms that secure the political commitment of local stakeholders and exact accountability for results. These mechanisms shall have a broad based participation, non-partisan leadership and sustained popular support to assure continued effort regardless of different political, economic, and socio-cultural conditions.[155] The MNCHN Strategy further calls upon DOH to develop and support the establishment, operation and maintenance of monitoring and evaluation mechanisms for local implementation of MNCHN Strategy. It calls for appropriate methodologies (e.g. maternal and perinatal death reviews) to be employed to establish baseline, track progress and assess impact of various interventions. It also emphasises that monitoring and evaluation mechanisms are transparent and have established dissemination channels.[156]



- In the Solomon Islands issues of accountability have been raised as a concern in many areas throughout the country and health is no exception. In making the best use of all available resources, accountability will be a significant way of making sure this happens, both at a financial and professional level.[157] The National Health Strategic Plan of Solomon Islands identifies strengthening of accountability as one of the key strategic areas.[158]

4 Recommendations: Using Human Rights to Fill the Gaps

As discussed above a good number of policy frameworks – do not explicitly contain a focus on reproductive rights generally or the right to health in particular. The role of human rights, including the right to health, in policymaking to reduce maternal mortality needs to be more strongly asserted and more widely integrated within policy-making. A policy that is based on human rights is likely to be equitable, inclusive, non-discriminatory, participatory and evidence-based.[159] In the context of maternal mortality, these features help to empower women and ensure that policies are likely to be sustainable, robust and effective. A human rights-based approach to reduce maternal mortality is therefore also likely to lead to improvements in sexual and reproductive health, including maternal health. [160]The following are some recommendations arising from a right-to-health approach for the reduction of maternal mortality. The list is not exhaustive.

Focus on the disadvantaged and marginal

MDG 5 is to reduce maternal mortality by three-quarters. However, the average condition of the population can be misleading as improvements in population level health indicators can mask a deteriorating situation for some disadvantaged groups. Human rights require that, so far as practical, all relevant data are disaggregated on the prohibited grounds of discrimination. This helps in monitoring the situation of marginal groups, such as women living in poverty, indigenous people, minorities and so on.[161] Governments should therefore be encouraged to collect disaggregated data on the progress made in the realisation of Goal 5.

Box 7: Maternal Mortality in Sri Lanka

In Sri Lanka, where a third of the population are estimated to live below the national poverty line, maternal mortality ratios are among the lowest in the developing world. Today, over 96% of deliveries in Sri Lanka are attended by a skilled birth attendant and over 90% take place in a health facility—with a referral system in place to ensure transport to one of 45 hospitals if complications occur. All first pregnancies and high-risk pregnancies are referred to health facilities with obstetricians. And a network of community midwives provides antenatal care for about 75% of women throughout their pregnancy.

Sri Lanka's success in preventing maternal deaths has been achieved against a backdrop of government commitment to improving education and health care. Over 93% of people today have access to basic health care. Health services are provided free of charge -- although over 50% of people use the private sector -- and few people are more than 1.4km from the nearest health centre. Maternal and child health services are available at community level as part of integrated reproductive health services. Contraception is used by over 60% of married women allowing them to space pregnancies and limit family size. This has also helped reduce maternal deaths.

Another driving force today is the education and relatively high status of women. Adult literacy rates among women are 88% and girls have access to free education up to university level. As a result, there has been an increase in the age of marriage – to 25 in 1993 -- and women are better able to take advantage of family planning and maternal health services.[162]

Planning

From the perspective of human rights, effective planning is absolutely critical. This is one of the weakest features in countries with alarmingly high rates of maternal mortality. Health planning aimed at preventing and reducing maternal mortality is complex and includes many elements such as situational analysis, impact assessments, and inter-sectoral coordination. The CESCR recognises "strategy and plan of action" as a core obligation arising from the right to health.[163] Governments should therefore be encouraged to effectively integrate maternal health issues in the overall health system plan. The Special Rapporteur's recent report to the Human Rights Council outlines the right to health approach to planning.[164] A systematic application of the recommendations made in the report can help in designing effective, inclusive plans necessary for the reduction of maternal mortality.

Strengthening health systems

Functioning health systems with an enabling environment that ensures adequate supplies, equipment, and infrastructure as well as an efficient and effective system of communication, referral, and transport are essential to averting the risks of maternal mortality. In many countries, maternal mortality generates narrow vertical interventions. Such interventions are not suitable for the long-term development of health systems. By drawing off resources and overloading fragile capacity, vertical interventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system.[165] To improve maternal health, gaps in the capacity and quality of health systems, and barriers to accessing health services must be identified and tackled at all levels, down to the community. A proper consideration of human rights, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems and result in the reduction of maternal mortality.

Health workers

As discussed, human resources are in crisis in many health systems. In many resource poor countries, obstetricians are not available at every appropriate health facility. Further, in some countries Governmental regulations prohibit anyone other than an anaesthesiologist from providing anaesthesia, therefore subjecting tens of thousands of women to the risk of death because they do not have access to caesarean section. Likewise, in some countries lower level health staff are not permitted to administer oxytocin, another life-saving measure. Unless the issue of health workers is carefully addressed, it is hard to imagine how maternal mortality can be reduced in many countries. Governments should institute simple but safe standards of care that can be provided by well-trained physicians, nurses, and other personnel,[166] taking into consideration overall human resource availability in country and population needs.

Box 8: Media Advocacy

Media advocacy can be useful in raising the visibility of maternal mortality as a human rights issue, and influence public opinion, and influence media`s own attitudes towards an issue. Maternal mortality is not just bio-medical, nor is it simply the lack of resources, it is a complex mix of economic and socio-cultural factors that lead to gender discrimination, neglect and deprivation and ultimately the denial of women's rights to well-being. Media visibility and independent journalism have an important role to play in creating the conditions for change and action, and promoting accountability.

International dimension

States have the obligation to take steps individually and through international assistance and cooperation towards the full realisation of various rights, including the right to health. Depending upon the availability of resources, developed countries should provide financial and

technical assistance to supplement the resources of developing countries with a view to preventing and reducing maternal mortality.[167] The right to health includes specific entitlements to maternal, child and sexual and reproductive health. Guaranteeing such freedoms and entitlements should be central to a State's development and other international policies.[168] CESCR confirms that donors should give particular priority to helping low-income countries realize their "core obligations" arising from the right to health.[169] Human rights require developed states to assist developing states in their efforts to reduce maternal mortality. In a recent resolution the UN Human Rights Council requested the states to "give renewed emphasis to maternal mortality and morbidity initiatives in their development partnerships and cooperation arrangements, including through honouring existing commitments and considering new commitments, and the exchange of effective practices and technical assistance to strengthen national capacities, as well as to integrate a human rights perspective into such initiatives, addressing the impact that discrimination against women has on maternal mortality and morbidity." [170]

Monitoring and accountability

Registering maternal deaths is crucial for preventing and reducing maternal mortality. Often in developing countries maternal deaths are not properly recorded. Monitoring maternal deaths is essential in order to assess the scale of maternal mortality, its causes, and whether measures are being taken to address the problem. Registering maternal deaths is only the starting point; a human rights-based approach requires that the deaths are explained, through a careful evaluation of the factors that lead to maternal deaths. [171]

Looking beyond EmOC

Anthony Costello in his study points out that a one-size-fits all policy for reduction of maternal mortality does not work and that policies need to be context-specific. According to randomised trials conducted by Costello in developing countries, community interventions can have a positive effect on reducing maternal mortality.[172] The study argues that context specific services and community-based strategies, in addition to health centre intrapartum care, can reduce maternal mortality.[173]

5 Conclusion

Preventable maternal mortality is closely related to a failure to give effect to reproductive rights. Maternal mortality can be drastically reduced by giving effect to freedoms and entitlements emanating from reproductive rights. Improving maternal health contributes to realisation of various MDGs, for instance, effective maternal health interventions can substantially reduce neonatal mortality. Similarly, studies have shown that maternal health conditions contribute substantially to burden of disease in women, and therefore high incidence of maternal morbidity and mortality contributes to loss of potential earning and pushes families into poverty. Addressing the problems in the health system that relate to maternal mortality—including inequitable access to EmOC and referral systems, cultural and economic barriers, and irrational and inequitable human resource regimes, would go a long way toward strengthening the health system overall. At the Women Deliver Conference in 2007, health and finance ministers made commitments to ensure that MDGs 4 and 5 are a high priority in national development plans and to advocate for women's health and human rights. It is time to fulfil this commitment; it is time to ensure that no more women die giving birth.

Appendix I

Key Maternal Health Related Policies/ Strategies

Bangladesh

- The Bangladesh National Strategy for Maternal Health 2001
- Bangladesh Health Nutrition and Population Sector Programme 2005-2010

Cambodia

- The National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010
- The Second Health Sector Strategic Plan of Cambodia 2008-2015
- The National Strategic Development Plan 2006-2010

India

- National Rural Health Mission 2005-2015
- Reproductive and Child Health Programme-II 2005
- Janani Suraksha Yojana 2006
- National Population Policy 2000

Indonesia

- National Development Program 2005
- Making Pregnancy Safer initiative 2000

Lao PDR

- National Population and Development Policy 1999
- National Reproductive Health Policy 2005
- Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015

Nepal

- Second Long Term Health Plan 1997-2017
- The Nepal Health Sector Programme Implementation Plan 2004-2009
- The National Reproductive Health Strategy 2008-2012

Pakistan

- Maternal and Newborn Child Health Program 2006-2012
- National Health Policy 2001

Philippines

- Reproductive Health Policy 2000
- Maternal Neonatal and Child Health National Strategy 2008

PNG

- Not Available

Solomon Islands

- National Health Strategic Plan 2006-2010

Timor-Leste

- National Reproductive Health Strategy 2004
- National Family Planning Policy 2005
- Health Policy Framework 2002

Appendix II
Components of Reproductive and Sexual Rights

12 sexual and reproductive rights have been proposed by International Planned Parenthood Federation (IPPF) in the "Charter on Sexual and Reproductive Rights". These rights are received from core human rights instruments, with the guideline part being based on internationally recognized instruments approved at four important conferences held by United Nations during 1993-1995, namely: United Nations World Conference on Human Rights (Vienna, 1993); United Nations International Conference on Population and Development (Cairo, 1994); United Nations World Summit for Social Development (Copenhagen, 1995); United Nations Fourth World Conference on Women (Beijing, 1995).

The Right to Life: The right to life should mean that: all persons have a right to life and no one shall be arbitrarily deprived of their life. In the area of sexual and reproductive health.

The Right to Liberty and Security of the Person: Everyone has the right to liberty and security.

The Right to Equality, and to be free from all forms of discrimination: All human beings are born free and equal in dignity and rights. The right of women should not be discriminated against by way of legislation, regulation, customs, practices, social and cultural patterns of conduct or other customs or practices.

The Right to Privacy: All persons have the right not to be subject to arbitrary interference with their privacy, family, home or correspondence.

The Right to Freedom of Thought: All persons have the right to freedom of thought, conscience and religion. The right to freedom of opinion and expression includes the right to hold opinions without interference and to seek, receive and impart information and ideas via any media.

The Right to Information and Education: All persons have the right to education and, in particular, to specific educational information to ensure the health and well-being of persons and families including information and advice on sexual and reproductive health and rights.

The Right to Choose whether or not to Marry and to Found and Plan a Family: The right to choose to marry and to found and plan a family is implicit in the right of all persons of full age to marry and to found a family without any limitation due to race, nationality or religion.

The Right to Decide whether or when to have Children: The right to decide whether or when to have children is implied by the right, that all persons have, to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right. Special protection should be accorded to women during a reasonable period before and after child-birth.

The Right to Health Care and Health Protection: All persons have a right to the enjoyment of the highest attainable standard of physical and mental health.

The Right to the Benefits of Scientific Progress: All persons have the right to enjoy the benefits of scientific progress and its applications.

The Right to Freedom of Assembly and Political Participation: Everyone has the right to freedom of peaceful assembly and association.

The Right to be Free from Torture and Ill Treatment: All persons have the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment and not to be subjected to medical or scientific treatment without free and informed consent.

Appendix III
Check list

Criteria	Human rights requirement	State compliance
Formal recognition	At the national level there needs to be recognition of reproductive rights including the right to the highest attainable standard of health in particular, as well as recognition of maternal mortality as a human rights issue.	
Resource availability	According to ICESCR State parties should undertake steps to the maximum of their available resources for the progressive realization of the rights contained in the Covenant. For its part CEDAW emphasizes State obligations "to take *appropriate* legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure women realize their right to healthcare."	
Combat discrimination, inequality and vulnerability	These are critical human rights features. Relevant maternal health services must be accessible – to all without discrimination. Outreach programmes must be put in place to ensure that disadvantaged women enjoy, in practice, the same access to maternal heath services as those who are advantaged.	

Criteria	Human rights requirement	State compliance
Available, accessible, acceptable, and quality care	If empirical evidence from public health indicates that EmoC, skilled attendance and referral networks are the keys to preventing and reducing maternal mortality, human rights law indicates that these aspects of care are to be made available, accessible, acceptable and adequate quality for the entire population. In this regard *Available:* An adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services. *Accessible:* a) Maternal health and sexual and reproductive health services which are both physically and financially accessible. b) Health services must be accessible on the basis of non -discrimination. c) The right to seek, receive and impart information and ideas concerning health issues, including information that can help prevent maternal mortality. *Acceptable:* All health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements. *Good quality:* Maternal health care services must be medically appropriate and good quality.	

Criteria	Human rights requirement	State compliance
Participation	All individuals and communities are entitled to active and informed participation on issues relating to their health. In the context of maternal health, this includes women's participation in policymak-ing, implementation and accountability.	
Accountability	Human rights approach to maternal mortality requires effective, accessible and transparent monitoring and accountability mechanisms. Registration of all maternal deaths is essential as well as a procedure for investigating the causes of such death.	

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