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**Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development**

# Update to the technical guidance on the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity

## Report of the Office of the United Nations High Commissioner for Human Rights

*Summary*

In the present report, prepared pursuant to Human Rights Council resolution 54/16, the Office of the United Nations High Commissioner for Human Rights provides an update to the technical guidance, issued in 2012, on the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity.



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# I. Background and context

1. The present report is submitted pursuant to Human Rights Council resolution 54/16, in which the Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to prepare an update to the technical guidance on the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity, informed by a global analysis from different regional perspectives of good practices, gaps and challenges and the main developments in the area of preventable maternal mortality and morbidity. The content of this update is grounded in the contributions received through consultations with experts, including health workers, from various regions and backgrounds, States, civil society organizations and United Nations entities, and in desk research and written submissions received in response to a questionnaire.[1]

## A. Building on the technical guidance on preventable maternal mortality and morbidity

2. The issuance in 2012 of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity[2] marked an important stride in understanding preventable maternal mortality and morbidity not only as a public health concern, but also as a human rights violation. The technical guidance contained suggested ways to tackle this deadliest manifestation of gender-based discrimination, affecting mainly women and adolescent girls in low- and middle-income countries and the most marginalized populations in high-income countries.[3]

3. The 2012 technical guidance offered clear direction on the steps needed to develop, implement and evaluate policies and programmes to address maternal health in line with human rights standards. A human rights-based approach is multifaceted and multisectoral, whereby sexual and reproductive health is promoted comprehensively, beyond isolated pathologies. Such an approach requires the explicit recognition of sexual and reproductive health and rights in constitutions and in legal and policy frameworks. It also requires robust accountability mechanisms that safeguard the enjoyment of these rights.

4. A human rights-based approach to reducing preventable maternal mortality and morbidity entails recognition of the complex interplay of socioeconomic, cultural and political factors that continue to put women's and girls' lives at risk. It is premised on the empowerment of women to claim their rights, which, if fulfilled, lead to lower maternal mortality rates. This approach, grounded in the human rights principles of universality, indivisibility, equality, non-discrimination, participation and accountability, requires expansion of the scope of interventions to cover, among other priorities, gender equality in all areas of life and access to education, work, poverty reduction and universal health coverage, as part of social protection and care and support systems.

5. For more than a decade, the Human Rights Council has repeatedly acknowledged the urgency of addressing maternal mortality and morbidity as a human rights issue. In a series of resolutions,[4] the Council affirmed the importance not only of addressing health system gaps, but also of tackling the root causes of preventable maternal deaths and the underlying social determinants of health, and of upholding the equal right of women to decide autonomously in matters regarding their own lives and health.

[1] Expert consultations were held in person in Geneva on 16 April 2025 and online on 30 April 2025. The Partnership for Maternal, Newborn and Child Health and OHCHR co-organized an online consultation with States on 29 April 2025, gathering technical experts from health ministries across the globe. See also https://www.ohchr.org/en/women/human-rights-based-approach-maternal-health.

[2] A/HRC/21/22, A/HRC/21/22/Corr.1 and A/HRC/21/22/Corr.2.

[3] See A/HRC/45/19 and A/HRC/54/34. See also https://www.who.int/publications/i/item/9789240108462 and https://www.who.int/publications/i/item/9789240104105.

[4] Human Rights Council resolutions 11/8, 15/17, 18/2, 21/6, 27/11, 33/18, 39/10, 47/25 and 54/16.

6. The present update to the technical guidance should be understood in conjunction with the initial guidance, OHCHR follow-up reports and materials, including the implementation guides addressed to a variety of stakeholders, and all the tools developed by the United Nations system to address preventable maternal mortality and morbidity.[5] The present update is intended to support efforts towards eliminating preventable maternal mortality and morbidity. Current rates of maternal mortality should not be seen as inevitable, but rather as reflective of a failure by States to ensure the full realization of women's human rights, in particular the sexual and reproductive health and rights of the most marginalized populations.

## B. Deteriorating global context

7. Poverty, limited access to education, health emergencies, economic crises, unsustainable debt burdens, austerity measures, unemployment, malnutrition, conflict, environmental degradation and natural hazards in some countries disproportionately affect women and girls, exposing them to increased risks of maternal mortality and morbidity. Moreover, discriminatory social norms and practices can translate into restrictive legal frameworks that undermine women's autonomy and decision-making power and limit their equal standing in the family and their access to education, employment and sexual and reproductive healthcare. This is compounded by gendered power imbalances in the political and economic spheres, which affect the achievement of lasting progress in maternal health.

8. While in the past decade considerable gains have been observed in different parts of the world, sexual and reproductive health and rights, recognized in regional and international human rights standards and consensus documents,[6] are increasingly challenged and often not treated as a priority, especially during crises, as shown during the coronavirus disease (COVID-19) pandemic. Regression related to sexual and reproductive health is being seen in some contexts, which could have an impact on maternal health.

9. The escalating gender pushback in many parts of the world is characterized by widespread misinformation and denial of factual, scientific evidence.[7] Recent data reveals that suspensions of and reductions in official development assistance for health are affecting essential healthcare, such as treatment related to malaria, HIV, tuberculosis, sexually transmitted infections, family planning and maternal and child health.[8] It has been reported that maternal health, already chronically underfunded, is now facing an even more dire situation owing to funding cuts of up to 92 per cent for maternal and child health.[9] As highlighted by the World Health Organization (WHO), the potential consequences for health systems worldwide is alarming, particularly in fragile settings where external funding is often critical to sustaining life-saving services.[10]

[5] See https://www.ohchr.org/en/women/human-rights-based-approach-maternal-health.

[6] See the relevant articles of the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. See also Committee on the Elimination of Discrimination against Women, general recommendations No. 19 (1992), No. 24 (1999) and No. 35 (2017); Committee on the Rights of the Child, general comment No. 13 (2011); Committee on Economic, Social and Cultural Rights, general comments No. 14 (2000), No. 22 (2016) and No. 24 (2017); and Committee against Torture, general comment No. 2 (2007). See further the Programme of Action of the International Conference on Population and Development (1994), the Beijing Platform for Action (1995), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) and the Social Charter of the Americas (2012).

[7] See Human Rights Council resolution 55/10. See also https://www.ohchr.org/en/statements-and-speeches/2023/06/turk-urges-solidarity-face-gender-equality-backlash and https://press.un.org/en/2023/sgsm21713.doc.htm.

[8] See https://www.who.int/publications/m/item/the-impact-of-suspensions-and-reductions-in-health-official-development-assistance-on-health-systems.

[9] See https://publications.jrc.ec.europa.eu/repository/handle/JRC142455.

[10] See https://www.who.int/publications/m/item/the-impact-of-suspensions-and-reductions-in-health-official-development-assistance-on-health-systems.

## C. Intolerable reality

10. As recent estimates show, many countries have recorded significant declines in maternal death rates, especially in regions that previously had the highest levels of maternal mortality. The global maternal mortality ratio decreased by 40 per cent between 2000 and 2023 although an upsurge was recorded during the COVID-19 pandemic (2020–2022).[11]

11. However, this advancement has been uneven across countries and regions and has slowed since 2016. Maternal mortality remains unacceptably high in some parts of the world.[12] As acknowledged by States, efforts made are insufficient to meet the very minimum target of reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, in line with target 3.1 of the Sustainable Development Goals.[13] Should the current situation persist, 80 per cent of States will not reach that objective, with the global maternal mortality ratio projected to be more than double the agreed target.[14]

12. The main direct obstetric causes of maternal mortality are well known – haemorrhage, hypertensive disorders, infections, unsafe abortions and complications from delivery – and effective and accessible solutions have long been identified. In 2023, one woman died approximately every two minutes owing to preventable causes related to pregnancy and childbirth. Approximately 92 per cent of these maternal deaths, most of which could have been prevented, occurred in low- and middle-income countries. Many women lacked access to modern contraception to ensure adequate birth spacing or were denied control over their pregnancies or essential antenatal monitoring. Others reached health facilities too late, only to find them ill-equipped, lacking the necessary interventions, medications or capacity to prevent and treat life-threatening complications.[15]

13. Perinatal mental health issues, including anxiety and depression, affect approximately 1 in 10 women in high-income countries and 1 in 5 women in low- and middle-income countries. These mental health issues can lead to suicide, which is becoming one of the leading causes of mortality during pregnancy and up to one year after birth in high-income countries.[16] Maternal mortality and morbidity have serious medical, psychological, social and economic consequences, affecting every aspect of the lives and well-being of women, infants, families and communities. The real magnitude of maternal morbidity remains unknown and is given far too little attention.

14. A deeper analysis of those most affected by maternal mortality is essential to better understand and address the phenomenon. Marginalized women, women living in poverty, women living in rural areas and women facing intersecting forms of discrimination, including on grounds of racial or ethnic origin, face higher rates of mortality. Adolescent pregnancy is linked to higher risks of maternal mortality. Each year, adolescent girls have an estimated 21 million pregnancies in low- and middle-income countries, half of which are forced or unintended.[17]

15. Women and girls in certain countries in sub-Saharan Africa are up to 400 times more likely to die from preventable causes related to pregnancy and birth than women in some high-income countries.[18] The highest estimated maternal mortality ratios are in western, central and eastern sub-Saharan Africa followed by the Caribbean, Oceania,[19] South and South-East Asia, southern and northern Africa and South and Central America.[20]

16. As noted, maternal mortality is largely preventable. As deplored during a consultation, “women are not dying from diseases that cannot be treated; they are dying because States

[11] See https://www.who.int/publications/i/item/9789240108462.
[12] Ibid.
[13] See https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_R5-en.pdf.
[14] See https://www.who.int/publications/i/item/9789240108462.
[15] Ibid.
[16] See https://www.who.int/publications/i/item/9789240098268.
[17] See https://www.who.int/publications/i/item/9789240104105.
[18] See https://www.who.int/publications/i/item/9789240108462.
[19] Excluding Australia and New Zealand.
[20] See https://www.who.int/publications/i/item/9789240108462.

decide who deserves to live". States must fulfil their international obligations and address maternal mortality and morbidity with a new sense of urgency.

# II. Eliminating preventable maternal mortality and morbidity: a human rights imperative

## A. Addressing the root causes and persistent gaps

17. The root causes of maternal mortality and morbidity lie in engrained gender inequalities and systemic failures that perpetuate disadvantage and risks, restricting women's access to sexual and reproductive healthcare. Insufficient prioritization of these issues in some countries and limited healthcare funding and accountability hamper effective interventions aimed at addressing inequalities.

### 1. Tackling gender inequalities and the underlying social determinants of health, including sexual and reproductive health

18. Patriarchal systems and discriminatory social norms continue to restrict women's rights in all spheres of life, including their sexual and reproductive health and rights, which are central to their enjoyment of the right to equality, as well as other rights, such as their right to health, education, work and an adequate standard of living. For example, in some countries, male guardianship, unjustified requirements for third-party authorization, [21] gender-based violence, child and forced marriage, school expulsion due to pregnancy, and female genital mutilation are some of the persisting harmful practices that contribute to maternal mortality and morbidity. Discriminatory laws and lack of access to essential sexual and reproductive services and information, or even their criminalization in some countries, are major obstacles to the prevention of maternal mortality and morbidity.[22]

19. Addressing harmful social norms, which drive gender inequalities in the family, in the economic, health, political and public spheres is crucial. Expanding access for girls to education,[23] including on their sexual and reproductive health and rights, tackling economic inequality and labour discrimination and ensuring their participation in economic, political, social and cultural development empowers women and girls and contributes to improved maternal health outcomes. Data show that each additional year of schooling reduces maternal mortality by enabling girls to delay marriage and childbirth.[24] Unsafe abortion remains a leading cause of preventable maternal mortality and morbidity in certain countries. It has been noted that restrictive legislation does not reduce its incidence, but drives it underground, increasing threats to the health and life of the women or adolescents concerned.[25] Human rights mechanisms have repeatedly called for legal access to safe abortion care, on the basis of their assessment of the relevant international standards.[26]

20. Structural inequalities in healthcare systems in some countries drive disparities in maternal health by restricting access to quality services, reinforcing social inequities and allowing systemic bias to persist, particularly affecting marginalized communities and individuals. For instance, women living in poverty in remote areas across the globe are the least likely to receive adequate healthcare.[27] Furthermore, worldwide, lower rates of literacy,

[21] See A/HRC/45/19.
[22] See https://www.who.int/publications/i/item/9789240108462. See also A/HRC/32/44 and https://www.ohchr.org/en/documents/thematic-reports/ahrc3244-thematic-analysis-eliminating-discrimination-against-women-area; https://www.who.int/publications/i/item/9789240039483; and https://www.unfpa.org/swp2024.
[23] See the Incheon Declaration and Framework for Action for the Implementation of Sustainable Development Goal 4.
[24] See https://www.who.int/publications/i/item/9789241508483.
[25] See https://www.who.int/publications/i/item/9789240039483.
[26] See CEDAW/C/POL/IR/1, A/HRC/32/44 and A/HRC/47/38.
[27] See https://www.unfpa.org/swp2024.

education and land ownership among women are linked to higher rates of maternal mortality and morbidity.[28]

### (a) Addressing multiple and intersecting forms of discrimination

21. Women and girls from marginalized and disadvantaged communities or groups – such as women and girls of African descent,[29] women and girls belonging to Indigenous groups, minorities and migrant populations, women and girls with disabilities, women and girls living with HIV, women and girls from certain castes, and lesbian and bisexual women – face multiple forms of discrimination that intersect and compound the risks of maternal mortality and morbidity.[30] The root causes of maternal mortality and morbidity do not exist in isolation, but rather intersect and reinforce each other in complex ways.[31] For example, poverty can limit access to education and economic opportunities, which in turn increases exposure to early marriage and gender-based violence, further hindering access to healthcare. Similarly, the collapse of health systems driven by various factors, including debt burden, can exacerbate the impact of systemic social issues, such as patriarchal norms, that restrict women's autonomy and decision-making power. These intersecting issues create unique challenges that require targeted interventions.

22. For instance, in certain countries, women of African descent are up to three times more likely to die while giving birth than white women.[32] The right to health includes the right to equality of access to the necessary healthcare, which requires, among other steps, that the causes of maternal mortality and morbidity that disproportionately affect those who face racial discrimination be addressed.[33]

23. Women with disabilities can face pressure to end their pregnancies owing to negative stereotypes about their parenting skills, leading sometimes to forced sterilization.[34] Such discriminatory practices can deter women and girls from seeking maternal healthcare and erode their trust in the healthcare system. They can also have a significant impact on the health of women and their newborns.[35]

24. In addition, it is critical to recognize that pregnancy and childbirth complications are among the leading causes of deaths of adolescent girls globally. It is therefore essential to prioritize the sexual and reproductive health and rights of this population, such as by prohibiting child and early marriage and ensuring access to quality education, including comprehensive sexuality education,[36] and access to contraception and abortion care, in particular in cases of sexual violence.[37]

25. To effectively address these intersecting forms of discrimination and the compounded risks faced by marginalized populations, it is essential to collect and use data disaggregated by race, ethnicity, disability, age, sexual orientation, gender identity, socioeconomic status and other relevant factors, in accordance with the human rights-based approach to data,[38] in order to uncover disparities and to design and monitor targeted interventions that ensure equal

[28] See A/HRC/45/19.
[29] See Committee on the Elimination of Racial Discrimination, general recommendation No. 37 (2024). See also https://www.unfpa.org/publications/maternal-health-analysis-women-and-girls-african-descent-americas.
[30] See A/HRC/39/26 and A/HRC/54/34. See also https://www.unfpa.org/publications/maternal-health-analysis-women-and-girls-african-descent-americas and https://www.ohchr.org/sites/default/files/Maternal_mortality_morbidity.pdf.
[31] See A/HRC/57/67.
[32] See https://www.unfpa.org/publications/maternal-health-analysis-women-and-girls-african-descent-americas.
[33] See Committee on the Elimination of Racial Discrimination, general recommendation No. 37 (2024).
[34] See A/72/133.
[35] Ibid.
[36] See Committee on the Rights of the Child, general comment No. 20 (2016).
[37] See https://www.who.int/publications/i/item/9789240108462.
[38] See https://www.ohchr.org/en/documents/tools-and-resources/human-rights-based-approach-data-leaving-no-one-behind-2030-agenda.

access to maternal healthcare. The policies and regulations developed should take into account the voices of these populations and be grounded in their lived realities.

### (b) Ensuring adequate maternal healthcare

26. Discriminatory practices combined with underfunded health systems, including lack of skilled healthcare personnel[39] and other factors, not only contribute to poor treatment of those seeking care, but also can lead to maternal mortality and morbidity. Detention over unpaid fees in the context of facility-based childbirth has been reported in certain countries, as have instances of physical and verbal abuse, humiliation, medical procedures (including sterilization) performed with coercion or without consent, lack of confidentiality, failure to obtain full informed consent, denial of pain medication, violations of privacy, refusal of admission to health facilities, and neglect during childbirth leading to life-threatening complications.[40]

27. These practices, which seek to limit women's autonomy and agency, are entrenched in harmful gender stereotypes about women's capacity to make decisions about their reproductive function, and can fuel the laws and practices that deny women their autonomy during pregnancy and childbirth. Such practices can serve as a deterrent for women to seek facility-based care, increasing the risk of life-threatening complications and contributing to maternal mortality and morbidity.[41] Social constructs about sexuality, pregnancy and motherhood can lead to healthcare providers not seeking women's informed consent, substituting instead their own beliefs about the best course of treatment and reducing women to objects of intervention without agency.[42] Such approaches, compounded in some contexts by social expectations regarding women's primary role as child bearers, mothers and caregivers, can result in failure to sufficiently prioritize women's health interests.[43]

28. There are reports of increased overmedicalization of pregnancy and childbirth in recent decades, at times contributing to poor quality of care and unfavourable outcomes for women and newborns.[44] Examples include requirements that only doctors provide certain services, such as obstetric care or pharmaceutical termination of pregnancy, and unnecessary resort to caesarean sections: although caesarean sections, when medically justified, can be crucial in preventing maternal mortality and morbidity, they otherwise entail unnecessary risks of complications and health problems.[45]

29. Ensuring adequate and respectful maternal healthcare, which respects the requirement for full informed consent and bodily autonomy and is considerate of diverse needs and cultural heritage, is essential for improving maternal health outcomes.[46] By addressing these issues, healthcare systems can enhance the quality of care for all women, ultimately reducing and eliminating preventable maternal mortality and morbidity.

## 2. Strengthening health systems

30. Fragile health systems, characterized by inadequate infrastructure, shortage of skilled healthcare providers and lack of essential medicine and equipment, are a major contributor

[39] See https://www.who.int/publications/i/item/9789240108462.
[40] See A/74/137 and A/HRC/41/33. See also https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1.
[41] See A/HRC/45/19.
[42] See A/HRC/32/44.
[43] See https://pmc.ncbi.nlm.nih.gov/articles/PMC7348458/ and https://www.figo.org/sites/default/files/2021-06/FIGO_Current%20Ethical%20Challenges%20Obstetric%20and%20Gynecologic%20Practice%20Research%20Education.pdf.
[44] See A/HRC/32/44.
[45] See https://www.who.int/news/item/16-06-2021-caesarean-section-rates-continue-to-rise-amid-growing-inequalities-in-access.
[46] See https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/HealthWorkers.pdf.

to maternal mortality and morbidity.[47] In many countries, health systems are underfunded, poorly managed and unable to meet the need for quality maternal healthcare services.[48] Sexual and reproductive health is an essential component of universal health coverage. A key element of universal health coverage is the reorientation of health systems towards primary healthcare, including the development of models of care that are adapted to local contexts and ensure comprehensive, integrated health services. Fragmentation within health systems – especially in maternal health, for which there is little continuity in the provision of care and which is rarely integrated into primary care provision – also contributes to maternal mortality and morbidity.[49]

### (a) Investing in community-based approaches, including midwifery models of care

31. Data show that midwifery models of care are optimal and cost-effective solutions that contribute to preventing maternal mortality and morbidity with minimal use of unnecessary interventions. These models ensure that women receive equitable, person-centred, respectful, integrated and quality care, starting pre-pregnancy and continuing all the way through the postnatal period, provided and coordinated by midwives working within collaborative interdisciplinary teams. Midwifery models of care have been reported not only to save women's lives, but also to improve the health and well-being of women and families, while placing the needs and autonomous decision-making of women at the centre of their care.[50]

32. Investment in the training and deployment of skilled midwives and expanding their scope of practice could enhance the level of care available to women in their communities.[51] However, these strategies have generally not been sufficiently implemented by States.[52] Practical and legal barriers persist across the globe. Some regulatory frameworks limit the ability of midwives to practice autonomously, which excludes many pregnant women from treatment by midwives. Further, midwifery is often conflated with nursing, and midwives commonly remain unrepresented or underrepresented on health system oversight bodies.

33. Traditional birth attendants, who assist with birth in some countries, are usually not recognized as legitimate healthcare providers and are not integrated into the formal healthcare system, meaning that they have no access to essential medicines and often no effective mechanism to refer patients who require medicalized care.[53] As noted in submissions and consultations, the result is especially problematic where birth attendants are the only providers available, where they also play a spiritual or cultural role or where historic abuse and discrimination deter certain populations from utilizing the formal healthcare sector.

34. Community health workers can also be trained to deliver basic maternal health services, educate their peers and provide referrals, thereby extending services to communities. Effective and consistent interprofessional collaboration among healthcare workers is key, and strategies need to be put in place to foster collaborative environments, help optimize resources and expand service delivery to ensure equitable access to comprehensive, quality maternal healthcare.[54]

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[47] See https://pmnch.who.int/our-work/focus-areas/maternal-newborn-and-child-health, https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-024-01941-8 and https://reliefweb.int/report/world/maternal-and-newborn-health-humanitarian-settings.

[48] See https://pmnch.who.int/news-and-events/news/item/07-04-2025-why-is-it-key-for-governments-to-invest-in-maternal-newborn-and-child-health.

[49] See A/HRC/21/22, A/HRC/21/22/Corr.1 and A/HRC/21/22/Corr.2. See also https://www.who.int/publications/m/item/investing-in-sexual-and-reproductive-health-and-rights-essential-elements-of-universal-health-coverage and https://www.who.int/publications/i/item/9789240052659.

[50] See https://www.who.int/publications/i/item/9789240098268.

[51] Ibid.

[52] See https://www.who.int/publications/i/item/9789240110199.

[53] See https://pmc.ncbi.nlm.nih.gov/articles/PMC9300345/ and https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-04753-5.

[54] See https://pmnch.who.int/resources/publications/m/item/women-s-and-children-s-health-in-conflict-settings-engaging-and-empowering-a-localized-innovative-health-workforce and https://www.who.int/publications/i/item/9789240110199.

### (b) Establishing comprehensive data-collection systems

35. Fragmented and underresourced national health information systems were raised in submissions and consultations as a major impediment to eliminating preventable maternal mortality and morbidity, resulting in poor data collection on maternal mortality and morbidity and hindering Governments' design and implementation of data-driven policy interventions.[55] For example, over two thirds of low-income countries have not yet established a standardized system to report causes of death. Globally, data on maternal morbidity is generally unavailable, signalling that the issue has not been prioritized.[56]

36. Reliable, transparent, timely and disaggregated data on births, deaths and causes of death – using a human rights-based approach to data – are essential for tracking maternal mortality, addressing inequalities and achieving global health goals. Special attention is needed to capture late maternal deaths – those that occur more than 42 days but less than one year post-partum – and to gather detailed data on marginalized populations, as national averages often mask significant disparities. National data registries should also collect data on the causes and conditions of every case of maternal morbidity.[57]

37. As noted by WHO, data quality and maternal mortality estimates have been improved in some countries by strengthening civil registration and vital statistics systems,[58] implementing maternal death surveillance methods and correcting errors in classification.[59] Transparency in data is critical: real numbers must be gathered, not hidden, including in relation to unsafe abortion, to ensure effective and impactful policies and programmes.[60] Many maternal deaths still go uncounted, which highlights the need for stronger national data systems and standardized international reporting.

38. When collecting and analysing disaggregated data, it is crucial for strict safeguards to be put in place in accordance with international human rights standards, notably to ensure privacy and confidentiality in data collection and the provision of services, as tracking sensitive information may violate individuals' rights to privacy and confidentiality and potentially put them in danger.[61] In addition, process indicators that reflect the availability and use of emergency obstetric care could facilitate targeted, responsive interventions to address preventable maternal mortality and morbidity.[62]

### (c) Shaping a human rights economy in the interest of maternal health

39. Economic systems that prioritize profit over human rights and rely on private providers to deliver healthcare often result in underinvestment in accessible public health services.[63] Healthcare privatization and practices by certain pharmaceutical companies have contributed to considerable disparities in and discriminatory access to maternal healthcare.[64] As highlighted in submissions and consultations, corporate influence on policymaking in some countries – such as through lobbying against regulations that prioritize equitable access to medicines and affordable maternal healthcare – has undermined efforts to ensure affordable and inclusive care. For instance, the pricing of and patents on essential drugs affect underfunded public health systems and patients, disproportionately burdening marginalized communities. The privatization of healthcare has been shown to deepen the exclusion of remote rural communities and increase patients' costs for reproductive healthcare. Where

[55] See A/HRC/21/22, A/HRC/21/22/Corr.1 and A/HRC/21/22/Corr.2.
[56] See A/HRC/45/19.
[57] See https://www.who.int/publications/i/item/9789240108462.
[58] See https://www.emro.who.int/civil-registration-statistics/about/what-are-civil-registration-and-vital-statistics-crvs-systems.html.
[59] See https://www.who.int/publications/i/item/9789240102262.
[60] See https://www.who.int/publications/i/item/9789240108462.
[61] See https://www.who.int/publications/i/item/9789240057104.
[62] See https://www.who.int/publications/i/item/9789241547734.
[63] See A/67/302 and A/HRC/56/28. See also https://policy-practice.oxfam.org/resources/sick-development-how-rich-country-government-and-world-bank-funding-to-for-prof-621529/#:~:text=Development%20finance%20institutions%20owned%20by,who%20cannot%20afford%20their%20bills.
[64] See A/73/396.

healthcare is heavily privatized or dependent on employment-based insurance schemes, women living in poverty, undocumented migrant women and women engaged in informal labour are more likely to be excluded from essential maternal healthcare, including access to medications.[65] States Parties to the International Covenant on Economic, Social and Cultural Rights are obliged to take steps, to the maximum of their available resources, with a view to achieving progressively the full realization of the right to health, including sexual and reproductive health. States Parties must therefore move as expeditiously and effectively as possible towards the full realization of the highest attainable standard of sexual and reproductive health.[66] States must also effectively monitor and regulate sectors such as private healthcare providers and health insurance companies to prevent violations or abuses of individuals' right to sexual and reproductive health.[67] The Committee on Economic, Social and Cultural rights has noted that States have an extraterritorial obligation to ensure that transnational corporations, such as pharmaceutical companies operating globally, do not violate the sexual and reproductive health and rights of people in other countries.[68]

40. Furthermore, the growing and increasingly costly debt burdens faced by many low- and middle-income countries divert resources away from essential social services, including healthcare.[69] Between 2021 and 2023, a total of 3.4 billion people lived in countries that spent more on interest payments than on either health or education.[70] This situation has led to cuts in public health spending in some countries, further undermining the capacity of health systems to provide quality maternal healthcare. Many low- and middle-income countries instead rely on fluctuating, often conditional, donor funding for maternal health, which exacerbates fragmentation in health systems rather than working towards sustainable domestic financing for maternal health as primary healthcare,[71] or on an expanding network of profit-driven providers, which limits equitable access to quality maternal healthcare.[72]

41. Many States lack the political commitment to address preventable maternal health and have failed to budget for national maternal health plans.[73] As of 2019, the cost of ending preventable maternal mortality and morbidity by 2030 was estimated at $115.5 billion, whereas development assistance was projected at $11.9 billion over the following decade.[74] Those prognoses are further affected by the recent suspension of or cuts in funding from major donor countries, despite the current global context with the unparalleled nature of conflicts. Donor States and international actors, including international development banks and international financial institutions, should enhance their funding in the area of sexual and reproductive health and rights. To this end, international assistance should not entail restrictions on the information or services necessary for the effective enjoyment of rights. Furthermore, donor States should not reinforce or condone legal, procedural, practical or social barriers to the full enjoyment of sexual and reproductive health and rights that exist in recipient countries. States should refrain, including when providing aid, from censoring, withholding, misrepresenting or criminalizing the provision of information on sexual and reproductive health, as such restrictions impede access to the relevant services.[75]

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[65] See https://www.who.int/publications/i/item/9789240011878, https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(24)00442-X/fulltext, https://pmc.ncbi.nlm.nih.gov/articles/PMC10276598/ and https://www.who.int/news-room/fact-sheets/detail/essential-medicines.

[66] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 33. See also International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

[67] See https://www.ohchr.org/sites/default/files/documents/publications/guidingprinciplesbusinesshr_en.pdf.

[68] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 60.

[69] See https://www.undp.org/publications/dfs-human-cost-inaction-poverty-social-protection-and-debt-servicing-2020-2023.

[70] See https://unctad.org/publication/world-of-debt. See also A/73/179.

[71] See https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00005-5/fulltext. See also A/67/3.

[72] See https://data.unicef.org/resources/healthy-mothers-healthy-babies/.

[73] See https://pmnch.who.int/news-and-events/news/item/07-04-2025-why-is-it-key-for-governments-to-invest-in-maternal-newborn-and-child-health.

[74] See https://www.unfpa.org/sites/default/files/pub-pdf/Transformative_results_journal_23-online.pdf and https://sites.google.com/unfpa.org/costing30s/home.

[75] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 41.

### 3. Promising practices

42. Over recent decades, States across all regions have pursued efforts to reshape their sexual and reproductive health landscapes, including maternal health, to address the needs of the most marginalized populations. Although political, economic and cultural settings differ, the reforms undertaken, according to submissions and consultations, tend to fall into five mutually reinforcing strands: legal, service-related, informational, structural and intersectional. National experiences have shown that resolute political will is an essential precondition for progress and a powerful driving force behind these changes, leading to the drastic reduction of maternal mortality and morbidity even in the most precarious socioeconomic contexts.

43. Recognizing that sustained progress can be achieved only by addressing the deeper social and economic inequalities that put some women at a greater risk of dying, a growing number of States from various regions have introduced the following measures: (a) universal health coverage to guarantee access to maternal health services through publicly-funded programmes, abolishing user fees or ensuring full coverage during pregnancy, during childbirth and post-partum; (b) decentralized care models, which integrate primary care with higher-level services, exemplifying efforts to streamline public system efficiency and reduce disparities, and which help bring services closer to women, especially those in marginalized or remote communities, and reduce costs associated with private care; and (c) expanded infrastructure and emergency transport systems, which are crucial for bridging geographical disparities, especially in rural or underserved regions, ensuring that marginalized and remote populations have access to maternal healthcare without prohibitive expenses or travel burdens. Some States are recognizing that reaching all women requires legal protections and service improvements established through an intersectional lens. Maternity wards in some countries are adopting anti-discrimination guidelines, training health workers on adequate, respectful maternal care and disability inclusion, and warning against implicit bias. More attention is also being paid to the needs of people who have historically been and continue to be discriminated against.

## B. Safeguarding access to maternal healthcare in crisis and humanitarian situations

44. Conflicts, natural disasters and climate change are major threats to maternal health, increasing risks of mortality and morbidity, especially for marginalized populations,[76] through damage to health infrastructure and impacts on health personnel, which limit access to healthcare, including essential sexual and reproductive health services. Most maternal deaths worldwide – 61.4 per cent of global maternal deaths – occur in humanitarian settings where already fragile healthcare systems are disrupted or shattered.[77] It has been estimated that 11 million pregnant women will require humanitarian aid in 2025.[78]

45. In crisis and humanitarian contexts, women and girls face additional challenges, such as displacement, food insecurity and breakdown of health services.[79] The threats to their health, well-being and rights, including in relation to sexual and reproductive health, and the risk of being subjected to gender-based violence are decidedly more pronounced.[80] Adolescent girls are additionally affected as they are torn from schools and family structures and owing to taboos concerning their sexuality, and higher rates of sexual assault and child

[76] See https://iawg.net/resources/examining-mnh-in-conflict-affected-contexts-country-profiles#:~:text=The%20Mortality%20in%20Humanitarian%20Settings,humanitarian%20response%20plans%20in%202023, https://www.who.int/publications/i/item/9789240073678 and https://www.unfpa.org/HAO2025.

[77] See https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

[78] See https://www.unfpa.org/HAO2025.

[79] See A/HRC/39/26 and A/HRC/42/24.

[80] See Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013). See also https://www.un.org/en/development/desa/population/migration/events/coordination/15/documents/papers/14_UNHCR_nd.pdf and https://www.unfpa.org/emergencies.

marriage have been reported among displaced girls aged 10 to 19.[81] Healthcare workers, too, are subject to extreme and dangerous conditions, making the delivery of quality maternal healthcare a challenge.

46. Preventing the destruction and ensuring the provision of sexual and reproductive health information and services, including maternal health services, in crisis and humanitarian settings is central to an effective response.[82] The protection offered by human rights conventions, including with respect to women and girls, does not cease in case of armed conflict. In such situations, international humanitarian law and international human rights law are complementary and not mutually exclusive spheres of law.[83] Practices inconsistent with international humanitarian law can therefore constitute simultaneous violations or abuses under international human rights law.

47. States must ensure comprehensive availability of sexual and reproductive health services in crises, in line with international law. Thus, the Committee on the Elimination of Discrimination against Women has recommended that States ensure that sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as fistula arising from sexual violence, complications of delivery or other reproductive health complications.[84] The Minimum Initial Service Package for Sexual and Reproductive Health should be incorporated into all humanitarian preparedness and response plans to ensure the timely delivery of life-saving sexual and reproductive health services.

48. As highlighted during consultations, even amid humanitarian crises, it has proven both possible and necessary to build maternal health systems that are duly prepared, anticipatory and inclusive. The emphasis on mobile outreach, digital connectivity and midwifery care signals a move beyond emergency relief toward durable solutions that safeguard lives.

## C. Ensuring effective accountability mechanisms

49. In the technical guidance, issued in 2012, on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity, the fundamental principle of accountability is placed at its core. Failure by a State to comply with its obligations to respect, protect and fulfil the right to health, including the right of access to quality sexual and reproductive healthcare and the obligation to address preventable maternal deaths and morbidity, would entail the

[81] See https://www.unfpa.org/publications/adolescent-girls-disaster-conflict and https://www.girlsnotbrides.org/learning-resources/resource-centre/child-marriage-conflict-crisis-affected-settings-evidence-practice/.

[82] See https://reproductiverights.org/wp-content/uploads/2021/06/SRHR-humanitarian-settings-6-2021.pdf.

[83] See Human Rights Committee, general comments No. 31 (2004) and No. 36 (2018); Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013); Committee on Economic, Social and Cultural Rights, general comment No. 12 (1999); E/C.12/2001/10; Human Rights Council resolution 39/10; General Assembly resolutions 44/25 and 61/106; and Security Council resolution 2467 (2019). See also https://www.ohchr.org/en/publications/special-issue-publications/international-legal-protection-human-rights-armed-conflict and https://www.icrc.org/de/node/119764#:~:text=Humanitarian%20Law%2C%20Human%20Rights%20and%20Refugee%20Law%20–%20Three%20Pillars,-Menschenrechte%20und%20HVR&text=International%20humanitarian%20law%2C%20refugee%20law,health%20and%20dignity%20of%20persons.

[84] Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013), para. 52 (c).

responsibility of the State.[85] Accountability mechanisms, such as legal redress, public inquiries and community, national and international human rights monitoring mechanisms play a crucial role in ensuring that States fulfil their obligations and take effective measures to eliminate preventable maternal mortality and morbidity.[86] In recent years, litigation efforts have been used to hold Governments accountable for the provision of quality maternal healthcare and the prevention of maternal mortality and morbidity.[87] However, it has been noted that litigation alone is generally not enough to guarantee these rights, particularly in countries with fragile health systems, a lack of political will or limited social mobilization to demand accountability.[88]

50. A human rights-based approach to preventable maternal mortality and morbidity is grounded in the accountability of numerous stakeholders and at all levels, both within and beyond the health sector. Ensuring professional and facility-level accountability is vital, with clear standards and oversight by licensing bodies and professional associations. While standards should be in place to ensure quality of care, individual health workers should not bear the burden of institutional failures: accountability should be aimed at systemic change. Health facilities should establish procedures for complaints and appeals that are supported by management, ethics committees and ombudspersons to assist both users and health workers.

51. States should also strengthen health systems, including reporting, monitoring and evaluation. To do so requires quantitative and qualitative indicators and the building and sharing of evidence, including through the collection of disaggregated data and qualitative experiences during childbirth, particularly among marginalized populations.[89]

52. Ensuring social or community accountability is critical. In line with the human rights-based approach, States should enable effective participation and empower communities to demand improved service delivery through awareness-raising and participatory mechanisms for all the voices to be heard.[90] Measures could include stakeholder meetings, public hearings, maternal health scorecards, village health-watch committees and citizen charters.[91] Both affected communities and health workers must be involved in the development of health policies and regulations and in the monitoring and evaluation of the provision of health services.

53. Business actors have a responsibility to respect women's sexual and reproductive health rights, and States have an obligation to act with due diligence to prevent human rights abuses committed by third parties, including non-State actors. Donor States should also uphold their human rights obligations in terms of international assistance and cooperation.[92]

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[85] See Committee on the Elimination of Discrimination against Women, *De Lourdes da Silva Pimentel et al. v. Brazil* (CEDAW/C/49/D/17/2008); and Committee on the Elimination of Racial Discrimination, general recommendation No. 37 (2024).

[86] See A/HRC/21/22, A/HRC/21/22/Corr.1, A/HRC/21/22/Corr.2, A/HRC/39/26 and A/HRC/45/19.

[87] See CEDAW/C/OP.8/PHL/1, https://www.ohchr.org/en/stories/2015/06/un-womens-committee-makes-inquiry-sexual-and-reproductive-health-rights-philippines, https://chr-observatories.uwazi.io/en/entity/kx4ih8ipdw, https://www.knchr.org/portals/0/reports/reproductive_health_report.pdf, https://www.cambridge.org/core/journals/journal-of-african-law/article/abs/contribution-of-ugandas-constitutional-court-petition-no-16-judgment-to-the-right-of-access-to-quality-emergency-obstetric-care-under-international-law/FB6118E58D14682D5F71C6E5EC24E60D and https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/RGuide_NHRInsts.pdf.

[88] See https://pmc.ncbi.nlm.nih.gov/articles/PMC10309149/.

[89] Ibid.

[90] See https://www.who.int/publications/i/item/9789241508483.

[91] See https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0196788.

[92] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016). See also http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf.

# III. Conclusions and recommendations

## A. Conclusions

54. **There is growing recognition of preventable maternal mortality and morbidity as a human rights issue, with initiatives targeting the root causes through legal reform, stronger health systems and greater inclusion of marginalized populations. There has been genuine progress in reducing maternal mortality rates – even in precarious settings – by, for instance, improving rural healthcare access. These successful strategies can be shared and adapted to various contexts. Yet these advances remain uneven amid persistent gender and other socioeconomic inequalities, fragile health infrastructure, and frequent political inertia towards reducing preventable maternal mortality and morbidity, in a global environment of growing hostility towards gender equality at large. Economic instability, conflict and environmental deterioration have exacerbated systemic failures that disproportionately harm women and girls. In addition, the level of maternal mortality reflects distressing realities regarding the systemic and intersecting forms of discrimination that women and girls face in systems still afflicted by patriarchy and structural racial discrimination**.

55. **Eliminating preventable maternal mortality and morbidity requires bold, systemic change and solidarity. States should invest in universal healthcare, including maternal healthcare, with community-based approaches at its centre, and in access for girls to quality education. Maternal health should be central to sustainable development efforts. Genuine accountability, inclusive and effective participation and strong, transparent data systems are essential. Maternal survival is a matter of justice, not just healthcare, and only a rights-based overhaul will ensure that no woman or girl dies from preventable causes.**

56. **Continued loss of life of the most marginalized women and girls due to systemic gender-based discrimination and sharp socioeconomic inequalities must end. Eradicating preventable maternal mortality and morbidity is not optional: it is a moral and human rights imperative involving clear legal obligations of States.**

## B. Recommendations

57. **States should formally recognize preventable maternal mortality and morbidity as a human rights issue, driven by structural inequalities, patriarchal norms and institutionalized discrimination. OHCHR therefore makes the recommendations set out below.**

58. **States should adopt a series of legal and policy measures, such as:**

(a) **Prohibiting harmful practices, including child marriage, female genital mutilation, male guardianship, school expulsion due to pregnancy, mistreatment, abuse and violence in reproductive healthcare and coercive sterilization;**

(b) **Aligning national laws with international standards in order, inter alia, to eliminate requirements for third-party authorization for healthcare and to ensure bodily autonomy;**

(c) **Amplifying girls' and women's agency and education, ensuring quality education free of charge and integrating comprehensive sexuality education, necessary to prevent adolescent pregnancies and delay dangerous childbearing;**

(d) **Enacting laws and policies to ensure access to the whole array of relevant sexual and reproductive services, including contraception and abortion care, in accordance with international standards;**

(e) **Enacting laws and policies on rights-based maternal healthcare;**

(f) **Strengthening multi-stakeholder capacity through training programmes for policymakers, judges, health workers and national human rights institutions on**

**rights-based maternal healthcare, with a focus on the struggle against intersectional discrimination faced by marginalized populations;**

(g) **Operationalizing the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity and the present update, as well as OHCHR implementation guides and interim reports and the wealth of United Nations tools available across all sectors, with ministries of health, education, finance and justice collaborating to address the social determinants of health – such as poverty – gender-based discrimination and violence, and discrimination on other grounds.**

59. **States should combat structural oppression and reconstruct health systems to dismantle patriarchal, colonial and racist legacies, by:**

(a) **Departing from privatized maternal care models that exclude low-income women;**

(b) **Ensuring that concerned business enterprises act in accordance with the Guiding Principles on Business and Human Rights to prevent abusive commercial practices with detrimental health outcomes;**

(c) **Prioritizing community-based approaches such as midwifery programmes and traditional birth attendants, with a focus on rural areas;**

(d) **Legislating to ensure non-discrimination in access to maternal healthcare.**

60. **States should mobilize resources for equitable health systems, by:**

(a) **Redirecting debt-relief and austerity savings into public health infrastructure;**

(b) **Including the full continuum of sexual and reproductive healthcare in national universal health coverage;**

(c) **Abolishing user fees for maternal care as part of universal health coverage and allocating sufficient and sustainable national budgets to maternal healthcare;**

(d) **Maintaining a list of essential medicines to guarantee the continuous supply of essential medicines and equipment free of charge and ensuring sufficient capacity to manage life-threatening conditions;**

(e) **Establishing emergency funding pools for sexual and reproductive health services in crisis, conflict and humanitarian settings to ensure continuity of care;**

(f) **Subsidizing midwifery training programmes, including in underserved regions;**

(g) **Strengthening support for and commitment to sexual and reproductive health and rights programming from donor States, including for maternal healthcare, upholding and advancing their human rights obligations and political commitments.**

61. **States should support community-based approaches, including by:**

(a) **Incorporating midwifery models of care into health system investments, policies and capacity-building efforts by developing legal and regulatory frameworks, ensuring access to quality midwifery education programmes aligned with the relevant standards, and enabling midwives to obtain licences and to practise autonomously in accordance with their training and competencies;**

(b) **Undertaking an assessment of the availability and use of traditional birth attendants where populations mainly rely on them, and developing a strategy to strengthen linkages to the healthcare system, ensuring continuity and quality standards of care and effective referral systems;**

(c) **Guaranteeing that midwives, traditional birth attendants and community health workers are able to practise legally, including by ensuring fair wages, safe working conditions, effective referral systems and inclusion in policy dialogues;**

(d) **Equipping community health workers to contribute to maternal health-care;**

(e) **Providing midwives, traditional birth attendants and community health workers with transport stipends, kits and means of mobile communication.**

62. **States should ensure strong and transparent data systems, by:**

(a) **Ensuring a human rights-based approach to data, including transparency and accountability, with no interference with maternal health reporting;**

(b) **Collaborating with United Nations entities and civil society to publish anonymized, disaggregated data on maternal outcomes;**

(c) **Commissioning independent audits of reviews of maternal deaths to counter underreporting;**

(d) **Using human rights indicators in reports on progress towards the Sustainable Development Goals.**

63. **In crisis and humanitarian settings, States should:**

(a) **Ensure stronger, duly prepared health systems and a coordinated, cross-sector approach;**

(b) **Incorporate the Minimum Initial Service Package for Sexual and Reproductive Health into all humanitarian preparedness and response plans;**

(c) **Ensure cross-border referral agreements to enable access for refugees and migrants to emergency obstetric care without fear of detention or deportation;**

(d) **Guarantee full compliance with international human rights law and international humanitarian law, with a specific focus on sexual and reproductive rights;**

(e) **Take proactive measures to prevent all violations that lead to maternal mortality and morbidity, including the obstruction of maternal healthcare and destruction of maternity facilities;**

(f) **Immediately stop ongoing violations, investigate them without delay and prosecute all individuals or entities responsible in accordance with international legal standards.**

64. **States should ensure robust accountability mechanisms, by:**

(a) **Establishing independent oversight bodies to investigate maternal deaths and abuses, ensuring the accountability of those responsible and providing victims with commensurate remedy;**

(b) **Collecting disaggregated data to assess possible racial bias or other intersecting forms of discrimination that may result in maternal mortality;**

(c) **Providing effective remedies for victims of coercive sterilization or denial of emergency care by healthcare facilities, in breach of international standards;**

(d) **Ensuring that aggrieved parties are able to challenge decisions or failures in court or through administrative tribunals, in an effective and accessible manner;**

(e) **Institutionalizing regular meaningful consultations, when designing laws, policies, programmes and budgets, with the individuals and communities directly affected and with diverse women's rights groups, adolescent representatives, representatives of Indigenous Peoples and organizations of persons with disabilities;**

(f) **Providing legal aid and protection to survivors of mistreatment, abuse and violence in reproductive healthcare and families of deceased women;**

(g) **Establishing and providing adequate financing for a reparation fund for victims of maternal health-related violations.**

65. **National human rights institutions should:**

(a) **Establish a dedicated programme to receive complaints, conduct unannounced facility visits and issue recommendations on reducing preventable maternal mortality and morbidity;**

(b) **Investigate cases of mistreatment, abuse and violence in reproductive healthcare, unlawful detention for non-payment of fees and forced sterilization, in public and private facilities, and refer cases for administrative redress and, where relevant, criminal prosecution;**

(c) **Produce annual maternal health scorecards, with data disaggregated by race, ethnicity, disability, age, location and any other relevant factors, and brief the parliament thereon;**

(d) **Train judges, health workers and police on international human rights obligations, ensuring the participation of marginalized women in such training;**

(e) **Submit information on preventable maternal mortality and morbidity to the United Nations human rights mechanisms in the context of the reviews of States.**

66. **International financial institutions should:**

(a) **Ensure that loans and grants are accompanied by maternal health impact assessments, and prohibit user fees for essential care;**

(b) **Ensure effective allocation of health-sector portfolios to rural clinics, midwife schools and commodity procurement for sexual and reproductive health;**

(c) **Support States so that debt-relief savings can be earmarked for maternal health infrastructure and workforce salaries;**

(d) **Embed gender-responsive budgeting and maternal health floors in macroeconomic programmes and project design;**

(e) **Integrate human rights into loan agreements, consultations and programme conditionalities, and design social spending targets to take account of spending in maternal health;**

(f) **Require companies to adhere to the Guiding Principles on Business and Human Rights, including fair pricing of obstetric medicines;**

(g) **Integrate maternal health into climate-adaptation and loss-and-damage financing windows, and recognize maternal health needs as eligible, budgeted and reported on within those funding streams.**

67. **Business enterprises should:**

(a) **Follow the Guiding Principles on Business and Human Rights, including fair pricing of obstetric medicines;**

(b) **Publish transparent pricing and license key obstetric drugs for generic manufacture in low-income markets;**

(c) **Adopt and publicly display a rights-based maternal healthcare charter and allow spot audits;**

(d) **Remove or label sexual and reproductive health disinformation and issue quarterly transparency reports, in particular on social media platforms.**

68. **Civil society organizations should obtain the necessary support for:**

(a) **Monitoring facilities for abuses, documenting cases of mistreatment, abuse and violence in reproductive healthcare and feeding evidence to national human rights institutions and human rights mechanisms;**

(b) **Advocating for increased political will on reducing preventable maternal mortality and morbidity by ensuring that the voices of those directly affected are brought to the forefront of advocacy efforts;**

(c) **Supporting community engagement on preventable maternal mortality and morbidity, including engaging in community education on comprehensive sexuality education, contraception and legal rights and prioritizing outreach to adolescents and marginalized communities;**

(d) **Pursuing various accountability tools to challenge, for example, disrespect, abuse, detention for non-payment, restrictions on termination of pregnancy and forced sterilization;**

(e) **Supporting accompaniment networks that link marginalized women to free legal aid, transport and respectful care, especially in humanitarian settings.**