

GENERAL ASSEMBLY, THIRD COMMITTEE

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ATTAINABLE STANDARD OF HEALTH²**

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President,
Distinguished Delegates,
Ladies and Gentleman,

By the time I finish my brief remarks to you this morning, ten women will have died in childbirth or from complications of pregnancy. Each year, there are over 500,000 maternal deaths. Most could be avoided by a few well-known interventions.

Nine of the ten women who, as I speak, will die are in Africa or Asia. While women in some rich countries have a 1 in 8,700 chance of dying in childbirth, women in some poor countries have a 1 in 10 chance of dying in childbirth.

For every woman who dies from obstetric complications, about 30 more suffer from injuries, infection and disabilities. Over 2 million women living in developing countries remain untreated for obstetric fistula, a devastating injury of childbirth. Fistula is easy to prevent and easy to treat.

These facts are especially shocking not only because they are preventable, but also because they expose profound health inequalities.

First, the burden of maternal mortality falls disproportionately on women in developing countries.

Second, in both developing and developed countries, the burden of maternal mortality falls disproportionately on ethnic minority women, indigenous women, and women living in poverty.

Third, there is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal mortality and morbidity. In other words, maternal mortality and morbidity reveal sharp discrepancies between men and women in their enjoyment of sexual and reproductive health rights.

I have a suspicion that if men had to give birth, then mortality and morbidity arising from childbirth would be taken more seriously, and attract more resources, than they do today!

¹ On the occasion of the presentation of the report A/61/338, dated 13 September 2006.

² For convenience, I use 'the right to health' or 'the right to the highest attainable standard of health' as a shorthand for the full formulation of the right as set out in article 12(1) International Covenant on Economic, Social and Cultural Rights.

In short, maternal mortality highlights multiple inequalities – global, ethnic and gender. And recurring throughout is the entrenched disadvantage of those living in poverty.

In recent years, an increasing number of countries have made progress in reducing maternal mortality. But progress has stagnated or been reversed in many of the countries with the highest maternal mortality rates. This is despite longstanding international commitments and initiatives to reduce maternal mortality.

Millennium Development Goal 5 aims to reduce maternal mortality by three quarters by 2015.

The Millennium Project Task Force charged with developing recommendations for Goal 5, emphasises the role of human rights, including the right to health, in the struggle against maternal mortality.

In my report, I begin to explore the relationship between maternal mortality and the right to the highest attainable standard of health. While the analysis needs more attention, I have no doubt that the right to health has a constructive contribution to make to maternal health policies because of its emphasis on guaranteeing primary health care; ensuring there are adequate numbers of health professionals; enhancing access to health services of good quality for all; addressing the underlying determinants of health, such as access to information on sexual and reproductive health; improving participation, monitoring and accountability; and so on.

In the 1990s, domestic violence was identified as a violation of human rights and this helped the global campaign against domestic violence gather momentum.

By the same token, the human rights community should mount a global human rights initiative against maternal mortality. Maternal mortality is not just a health or humanitarian issue – it is a human rights issue. Avoidable maternal mortality violates women's rights to life, health, equality and non-discrimination. The human rights community should take up maternal mortality just as vigorously as it does extrajudicial executions, disappearances, arbitrary detention, and prisoners of conscience.

The scale of maternal mortality is just as large as these other extremely serious human rights issues – if not more so.

In 2005, about 2,250 people received a death sentence and were executed. This is probably an underestimate. Let's multiple it by more than four, let's say 10,000 people were executed in 2005. How many maternal deaths were there in the same period? About 500,000.

Since 1980, the Working Group on Disappearances has taken up about 50,000 cases. Of course, the Working Group was unable to take up all the cases of disappearances in this 26-year period. So let's multiply the figure by twenty, let's say there were one million disappearances over 26 years. That is the same number of maternal deaths as took place in the last twenty-four months.

We all agree that disappearances are an extremely serious human rights problem. My point is: so is maternal mortality. It is time to recognise that avoidable maternal mortality is a human rights problem on a massive scale. Many have a role to play in the struggle against this human rights catastrophe: central government, the managers of health facilities, the international community, as well as families and communities at the local level. Not only must donors play their part by helping developing countries, they must also examine their own domestic policies where disaggregated data often expose discriminatory maternal health outcomes demanding vigorous attention.

I accept that more people die each year from tuberculosis and malaria than maternal mortality. But if we are to tackle maternal mortality, we will have to construct basic, good, accessible health systems from which all will benefit. In other words, tackling maternal mortality is a strategy for achieving a more ambitious, far-reaching goal: establishing effective, integrated, responsive health systems, encompassing health care and the underlying determinants of health, that are accessible to all.

Time permits me to only mention the second issue raised in my report: access to medicines.

Access to medicines forms an indispensable part of the right to the highest attainable standard of health. Like maternal mortality, enhancing access to medicines forms part of the Millennium Development Goals.

Gross inequity in access to medicines remains the overriding feature of the world pharmaceutical situation. Average per capita spending on medicines in high-income countries is 100 times higher than in low-income countries. 15% of the world's population consumes over 90% of the world's production of pharmaceuticals.

The report examines access to medicines through the right to health analytical framework that has been developed in recent years. It highlights the need for a reliable system for the supply of good quality medicines that are affordable to all, including those living in poverty and other disadvantaged groups. The record suggests that inadequate public funding in the health sector tends to make medicines less affordable. The report draws attention to the problem of corruption. As the head of Nigeria's Drug Authority put it: "Drug counterfeiting, facilitated by corruption, kills en masse and anybody can be a victim". The report argues that a right to health policy is by definition an anti-corruption policy.

From the right to health perspective, access to *existing* medicines must be equitable. Additionally, more research and development is needed to promote the availability of new drugs for those diseases causing a heavy burden in developing countries. Within a framework of international assistance and cooperation, States should resort to a variety of incentives in order to influence research and development into these specific health needs.

Of course, States have the primary responsibility for enhancing access to medicines. But, as the Millennium Development Goals recognise, this is a shared responsibility. If there is to be an increase in access to medicines, numerous national and

international actors have a role to play. The MDGs explicitly recognise that pharmaceutical companies are among those who share this responsibility.

For this reason, my report begins to explore the specific responsibilities of pharmaceutical companies in relation to access to medicines. I have begun discussing these issues with various actors, including pharmaceutical companies. With a view to being as practical and constructive as possible, I am preparing - by way of a consultative process with a wide-range of parties - some draft guidelines for States and pharmaceutical companies on access to medicines. I see little merit in arguing that States and pharmaceutical companies have legal or ethical responsibilities without also offering guidance on what these responsibilities are in the specific context of access to medicines.

This is a challenging project that I will report on further, as it develops, to the Human Rights Council.

President, I close with the reminder that, since I began speaking, ten women have died in childbirth or from complications of pregnancy. Ten more avoidable maternal deaths. Ten more human rights violations.
