MATERNAL MORTALITY AND MORBIDITY

In 2013, some 289,000 women died during or immediately following pregnancy and childbirth.

According to the World Health Organization, *"The maternal mortality ratio in developing countries in 2013 is 230 per 100,000 live births versus 16 per 100,000 live births in developed countries. There are also large disparities within countries, between women with high and low income and between women living in rural and urban areas."*[1]

Often seen as a public health concern, the issue of maternal mortality and morbidity must also be understood as a matter of human rights. International human rights treaties have clarified States' obligations in relation to maternal mortality and morbidity and recognized violations of women's rights to life, to the highest attainable standard of health, and to equality and non-discrimination in this regard.

A maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy… from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[2] The main causes of maternal death include severe bleeding, infection, unsafe abortion, high blood pressure, and prolonged or obstructed labour. Most maternal deaths and disabilities can be prevented through effective interventions and care during pregnancy and delivery.[3]

According to the Convention on the Elimination of All Forms of Discrimination Against Women, "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary."[4] The Committee on the Elimination of Discrimination Against Women has also established that the lack of appropriate maternal health services that meet the specific and distinctive health needs and interests of women violate both the right to health and the right to non-discrimination.[5] The International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the right to health,[6] which includes the freedom "to control one's health and body, including sexual and reproductive freedom."[7] The Committee on Economic, Social and Cultural Rights has further explained that State obligations under the Covenant include the obligation to "ensure reproductive, maternal (pre-natal as well as post-natal) and child health care."[8] Several treaty bodies have also characterized preventable maternal mortality as a violation of women's right to life.[9]

ON AVERAGE, EVERY DAY APPROXIMATELY 800 WOMEN DIE FROM **PREVENTABLE CAUSES RELATED TO PREGNANCY AND CHILDBIRTH**

99% OF ALL MATERNAL DEATHS OCCUR IN DEVELOPING COUNTRIES

MATERNAL MORTALITY IS HIGHER FOR WOMEN **LIVING IN RURAL AREAS AND POORER COMMUNITIES**

YOUNG ADOLESCENTS FACE A HIGHER RISK OF COMPLICATIONS AND DEATH AS A RESULT OF PREGNANCY THAN OLDER WOMEN

Source: World Health Organization, Maternal Mortality, Fact sheet N°348, May 2014

Reducing maternal mortality and morbidity remains at the center of national and international commitments. At the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, States recognized the right of women to go through pregnancy safely. States also committed to reduce the maternal mortality ratio by three quarters, between 1990 and 2015 in the Millennium Development Goals.

The United Nations High Commissioner for Human Rights has produced a body of work in recent years emphasizing that maternal mortality and morbidity is a matter of human rights. The first report of the High Commissioner to the Human Rights Council in 2010 on maternal mortality and morbidity lays out a conceptual framework for understanding the human rights dimensions of maternal mortality and morbidity. The report outlines seven principles which underpin a human rights based approach in this area: **accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination**.[10]

In a second report, presented in 2011, the High Commissioner identified common features of good practices in applying a human rights based approach to the issue of maternal mortality and morbidity. These include: **enhancing the status of women, ensuring sexual and reproductive health rights, strengthening health systems, addressing unsafe abortion, and improving monitoring and evaluation**.[11]

ESTIMATES OF MATERNAL MORTALITY RATIO AND MATERNAL DEATHS IN 2013

Maternal mortality ratio = maternal deaths per 100,000 live births

REGION	MATERNAL MORTALITY RATIO	NUMBER OF MATERNAL DEATHS
NORTHERN AFRICA	69	2700
SUB-SAHARAN AFRICA	510	179000
EASTERN ASIA	33	6400
SOUTHERN ASIA	190	69000
SOUTH-EASTERN ASIA	140	16000
WESTERN ASIA	74	3600
CAUCASUS & CENTRAL ASIA	39	690
LATIN AMERICA & CARIBBEAN	85	9300
OCEANIA	190	510
WORLD	210	289000

Source: World Health Organization and others, Trends in Maternal mortality: 1990 to 2013

KEY ISSUES

1 AN EFFECTIVE AND INTEGRATED HEALTH CARE SYSTEM IS CRUCIAL TO PREVENT MATERNAL DEATHS AND INJURIES

A functioning health system requires adequate supplies, equipment, and infrastructure, as well as an efficient system of communication, referral and transport.

Under the right to health, women are entitled to services that have been shown to reduce maternal mortality and morbidity, including access to skilled attendance at birth, emergency obstetric care, post-partum care, safe abortion services where it is legal, and other sexual and reproductive health-care services. In addition to these services, the right to health must also be understood to encompass "an entitlement to an effective and integrated health system."[12]

States are responsible for the actions of its private medical institutions.

The Committee on the Elimination of Discrimination Against Women has expressed concerns about the transfer of State health functions to private institutions and has underscored that States "cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies."[13] In *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, the Committee stressed that the State is directly responsible for the actions of its private medical institutions when it outsources its medical services, and that it maintains a duty to regulate and monitor private health-care institutions in line with its due diligence obligations.[14]

IN THE CASE OF *ALYNE DA SILVA PIMENTEL TEIXEIRA (DECEASED) V. BRAZIL*, the victim, a woman of African descent, died after a stillbirth and serious postnatal complications. Failures in diagnosing the complications suffered by the victim, delays in treating those complications, delays in referring her to a hospital with superior facilities and failures in the transmission of her records between health facilities, followed by lack of adequate response and redress for these failures, resulted in a finding of violations of the Committee on the Elimination of Discrimination Against Women. The Committee has established that the State must ensure that its maternal health services meet the specific needs of women, that policies on maternal health are implemented in practice, and that adequate judicial remedies and effective protection are provided without discrimination.

2 DISCRIMINATION BASED ON SEX IS AN UNDERLYING FACTOR THAT CONTRIBUTES TO MATERNAL MORTALITY AND MORBIDITY

Discrimination feeds the root causes which prevent women from accessing the services they require.

Women and girls have less resources and education to enable them to access healthcare services. Poverty, income inequality and gender discrimination affect women's enjoyment of their sexual and reproductive health and rights.[15]
The Committee on Economic, Social and Cultural Rights has established that "health facilities, goods and services must be affordable for all," including for socially disadvantaged groups.[16] States should provide free services to women living in poverty during pregnancy, delivery and post-partum periods.[17]

IN THE CASE OF THE *XÁKMOK KÁSEK INDIGENOUS COMMUNITY*, one of the victims was an indigenous woman who died from complications while in labor and did not receive medical attention. The Inter-American Court of Human Rights declared that the State violated the right to life **"because it failed to take the required positive measures, within its powers, that could reasonably be expected to prevent or to avoid the risk to the right to life."**[18]

The Court underscored that **"States must design appropriate health-care policies that permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate pre-natal and post-partum care, and legal and administrative instruments for health-care policies that permit cases of maternal mortality to be documented adequately."**[19]

Failure to provide services that only women need is a form of discrimination.

When high rates of maternal mortality and morbidity are attributable to Government failure "to use its available resources to take measures necessary to address the preventable causes of maternal death and ensure availability, accessibility, acceptability and good quality of services,"[20] this is a manifestation of discrimination against women and must be redressed immediately.

Part of protecting women's rights in this area is ensuring access to safe abortion, where legal, and to post abortion care because unsafe abortion is one of the five major causes of maternal death.[21] The Committee on the Elimination of Discrimination Against Women recommended that States increase access to family planning services[22] to reduce maternal deaths that result from unsafe,[23] clandestine[24] or illegal abortions;[25] and to ensure access to post-abortion care.[26]

STATES ARE OBLIGED UNDER INTERNATIONAL HUMAN RIGHTS LAW TO RESPECT, PROTECT AND FULFIL HUMAN RIGHTS IN RELATION TO MATERNAL HEALTH, PREGNANCY AND CHILDBIRTH

RESPECT The Committee on the Elimination of Discrimination Against Women has identified "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures" as a violation of the State obligation to refrain from interfering with the enjoyment of the right to health.[27]

PROTECT States are responsible for exercising due diligence, or acting with a certain standard of care, to ensure that non-governmental actors, including private service providers, insurance and pharmaceutical companies, and manufacturers of health-related goods and equipment, as well as community and family members, comply with certain standards.[28]

FULFIL States should adopt legislative, administrative, budgetary, judicial, and other measures to prevent maternal deaths and injury. States' failure to reduce maternal mortality may breach their obligation to ensure women's access to health care.[29]

The provision of maternal health services is comparable to a core obligation which cannot be derogated from under any circumstances. States need to ensure the ***availability, accessibility, acceptability*** and ***good quality*** of sexual and reproductive health services, including their affordability.[30]

3 MARGINALIZED WOMEN ARE AT HIGHER RISK OF VIOLATIONS RELATED TO MATERNAL MORTALITY AND MORBIDITY

Certain groups of women and girls are subjected to multiple forms of discrimination.

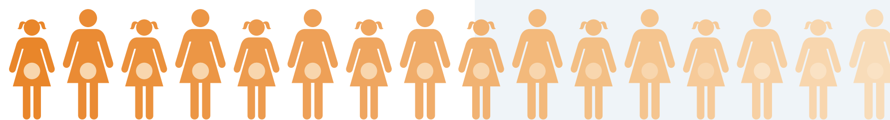
This impacts not only their access to facilities but also the way in which they are treated at facilities, which in turn affects their willingness to return to such facilities. The Committee on the Elimination of Discrimination Against Women has emphasized the linkages between discrimination on the basis of sex and other factors such as race, ethnicity, religion or belief, health status, age, class, caste, sexual orientation and gender identity.[31]

Human rights bodies have recommended States adopt measures to address maternal mortality and morbidity among marginalized groups, including young,[32] poor,[33] rural,[34] indigenous,[35] minority women[36] and migrant workers.[37]

Girls and adolescents face particular human rights issues which make them the highest risk group for maternal mortality and morbidity.

They encounter specific challenges in terms of access to information, including comprehensive sexuality education, and access to sexual and reproductive health services. Child and forced marriage, which disproportionately affects girls, contributes to the likelihood of girls becoming pregnant before they are ready physically or mentally. Concerning adolescents, the Committee on the Rights of the Child has recommended that States develop and implement measures to address their specific challenges in terms of access to information, including comprehensive sexuality education, and access to sexual and reproductive health services.[38]

IN 2012 the United Nations Human Rights Office developed technical guidance on applying a rights-based approach to the reduction of preventable maternal mortality and morbidity. This guidance operationalizes human rights by offering concrete advice on what human rights would require at different stages in the policy cycle.[39]



NOTES

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4 Article 12(2).
5 Committee on the Elimination of Discrimination Against Women, *Alyne da Silva Pimentel v. Brazil*, CEDAW/C/49/D/17/2008 (2011), paras. 7.4, 7.7.
6 Article 12.
7 General Comment 14 (2000) on the right to the highest attainable standard of health, paras. 8, 44(a).
8 Ibid., para. 44(a).
9 Human Rights Committee, Concluding Observations on Mali, CCPR/CO/77/MLI (2003), para. 14; Committee on the Elimination of Discrimination Against Women, Concluding Observations on Belize, A/54/38 (1999), para. 56; Colombia, A/54/38 (1999), para. 393; Dominican Republic, A/54/38 (1998), para. 337.
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11 Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity, A/HRC/18/27 (2011).
12 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338 (2006), paras. 13-14.
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14 *Alyne da Silva Pimentel v. Brazil*, para. 7.5.
15 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, A/HRC/21/22 (2012), para. 13.
16 General Comment 14, para. 12(b).
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19 Ibid., para. 233.
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21 A/HRC/18/27 (2011), para. 29.
22 Concluding Observations on Burkina Faso, A/60/38 (2005), para. 350; Cape Verde, CEDAW/C/CPV/CO/6 (2006), para. 30; Vanuatu, CEDAW/C/VUT/CO/3 (2007), para. 35; Peru, CEDAW/C/PER/CO/6 (2007), para. 25; Eritrea, CEDAW/C/ERI/CO/3 (2006), para. 23.
23 Concluding Observations on Dominican Republic, A/59/38(SUPP) (2004), paras. 308, 309; Myanmar, A/55/38 (2000), para. 130; Paraguay, A/60/38 (Supp) (2005), paras. 287-288.
24 Concluding Observations on Burundi, A/56/38(Part 1) (2001), para. 62; Lebanon, A/60/38 (2005), para. 112; Mali, CEDAW/C/MLI/CO/5 (2006), para. 34.
25 Concluding Observations on Colombia, CEDAW/C/COL/CO/6 (2007), paras. 22-23.
26 Concluding Observations on Brazil, CEDAW/C/BRA/CO/6 (2007), paras. 29-30; Chile, CEDAW/C/CHI/CO/4 (2006), para. 20; Honduras, CEDAW/C/HON/CO/6 (2007), para. 25; Nicaragua, CEDAW/C/NIC/CO/6 (2007), para. 18; Pakistan, CEDAW/C/PAK/CO/3 (2007), para. 41; Philippines, CEDAW/C/PHI/CO/6 (2006), para. 28.
27 General Recommendation 24, para. 14.
28 A/HRC/21/22, para. 22.
29 Committee on the Elimination of Discrimination Against Women, General Recommendation 24, para. 17; Committee on Economic, Social and Cultural Rights, General Comment 14, para. 37.
30 Committee on Economic, Social and Cultural Rights, General Comment 14, paras. 44(a), 12(b); Committee on the Elimination of Discrimination Against Women, General Recommendation 24, para. 21.
31 General Recommendation 28 (2010) on the core obligations of States Parties, para. 18; *Alyne da Silva Pimentel v. Brazil*, para. 7.7.
32 Human Rights Committee, Concluding Observations on Ecuador, CCPR/C/79/Add.92 (1998), para. 11.
33 Human Rights Committee, Concluding Observations on Argentina, CCPR/CO/70/ARG (2000), para. 14.
34 Ibid.
35 Committee on the Elimination of Discrimination Against Women, Concluding Observations on Panama, CEDAW/C/PAN/CO/7 (2010), para. 43; Ecuador, CEDAW/C/ECU/CO/7 (2008), paras. 24 25; Committee on the Rights of the Child, Concluding Observations on Paraguay, CRC/C/PRY/CO/3 (2010), paras. 79-80; Mexico, CRC/C/MEX/CO/3 (2006), paras. 72-73.
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37 Committee on the Rights of the Child, Concluding Observations on Mexico, CRC/C/MEX/CO/3 (2006), para. 72.
38 General Comment 4 (2003) on adolescent health and development, para. 31(a)-(c); General Comment 15 (2013) on the right of the child to the enjoyment of highest attainable standard of health, para. 56.
39 A/HRC/21/22.