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Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

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

Good practices and challenges to respecting, protecting and fulfilling all human rights in the elimination of preventable maternal mortality and morbidity

Follow-up report of the United Nations High Commissioner for Human Rights

Summary

In the present report, submitted pursuant to Human Rights Council resolution 39/10, the United Nations High Commissioner for Human Rights outlines initiatives related to the application 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. The report also includes an analysis of maternal morbidity as a human rights concern, and conclusions and recommendations.

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I. Introduction

1. In September 2012, the Human Rights Council adopted resolution 21/6, in which it welcomed the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes for the reduction of preventable maternal mortality and morbidity. Follow-up implementation reports have been produced, in 2014 (A/HRC/27/20), in 2016 (A/HRC/33/24) and in 2018 (A/HRC/39/26), as requested by the Council. In September 2018, in its resolution 39/10, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a follow-up report on good practices and challenges to respecting, protecting and fulfilling all human rights in the elimination of preventable maternal mortality and morbidity, including through the utilization of the technical guidance. The present report is submitted in response to that request.

2. The present report includes details of initiatives, good practices and challenges related to the implementation of the technical guidance and a human rights-based approach more generally. It is based on submissions received in response to a note verbale circulated on 11 November 2019, and on research and information obtained from relevant stakeholders.[1] Section IV, which also draws from the submissions received, combined with research, provides an analysis of maternal morbidity as a human rights concern, a dimension that has often been neglected in policies and programmes on preventing maternal mortality and morbidity. The High Commissioner concludes with recommendations on the implementation of a human rights-based approach to maternal mortality and morbidity, with a particular focus on maternal morbidity.

II. Implementation of a human rights-based approach to the reduction of preventable maternal mortality and morbidity

3. The technical guidance on the implementation of a human rights-based approach to the application of policies and programmes for the reduction of preventable maternal mortality and morbidity provides detailed guidance on the steps required to develop, implement and evaluate policies and programmes on maternal health. It follows the policy cycle of planning, budgeting, implementation, monitoring, review and oversight, and remedies. Through the identification of rights holders and their entitlements and corresponding duty bearers and their obligations, a human rights-based approach aims to identify potential human rights concerns, establish who is responsible for taking corrective action and determine how action is most appropriately taken. The examples provided in the submissions, as documented below, are important illustrations of how this approach may be operationalized.

4. Since 2018, numerous efforts have been documented to implement a rights-based approach to the reduction of preventable maternal mortality and morbidity, including through the implementation of the technical guidance. Tools developed based on the technical guidance, such as the reflection guides,[2] have been widely disseminated in meetings with relevant ministries, civil society organizations and United Nations entities, as well as with targeted stakeholder groups, such as national human rights institutions and representatives of the judiciary. At the global level, numerous publications and other documents have referred to the technical guidance, facilitating its use.[3]

[1] For the complete list of submissions, see www.ohchr.org/EN/Issues/Women/WRGS/Pages/TechnicalGuidanceMMM.aspx.

[2] See www.ohchr.org/EN/Issues/Women/WRGS/Pages/MaternalAndChildHealth.aspx.

[3] See A/74/137; Alicia Ely Yamin and Paola Bergallo, “Narratives of essentialism and exceptionalism: the challenges and possibilities of using human rights to improve access to safe abortion”, *Health and Human Rights Journal*, vol. 19, No. 1 (June 2017); Uchenna Emelonye, Abigail Uchenna Emelonye and Uchenna Ponfa Emelonye, “Preventing maternal mortality in Nigeria: a human rights imperative”, *US-China Law Review*, vol. 16, No. 4 (2019); Agegnehu Bante and others, “Respectful maternity care and associated factors among women who delivered at Harar hospitals, eastern Ethiopia: a cross

5. Human rights treaty bodies, such as the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women, have continued to advise States to utilize the technical guidance in their policies and programmes on sexual and reproductive health, including maternal health.[4]

6. In its 2018–2021 management plan, the Office of the United Nations High Commissioner for Human Rights (OHCHR) included, for the first time as a priority, a commitment to work to ensure that public health approaches comply with international human rights principles and standards.[5] To achieve this output, OHCHR has been prioritizing partnerships with key stakeholders, including governments, civil society and other United Nations entities.

7. OHCHR has also emphasized the importance of taking a human rights-based approach to maternal health, and sexual and reproductive health, in its work during the coronavirus disease (COVID-19) pandemic. It has engaged with authorities in several countries on ways to reduce the risk of an increased rate of maternal mortality and morbidity.[6] Numerous Member States have also affirmed that ensuring sexual and reproductive health services in line with human rights obligations is necessary to prevent a rise in maternal mortality and morbidity in the context of the COVID-19 pandemic.[7]

A. National-level multi-stakeholder processes

8. Participatory multi-stakeholder processes are an important component of rights-based approaches. These provide the occasion to engage in a situational analysis, which facilitates understanding about human rights gaps related to sexual and reproductive health, including maternal health. The findings should be the subject of deliberation in a process that is inclusive and multisectoral, and the results of such discussions, including prioritization of key actions needed to reduce maternal mortality and morbidity, should influence relevant national plans and policies.

9. Countries such as Australia, Ethiopia, Latvia, Mexico, Nepal and New Zealand reported the convening of multi-stakeholder processes to consider and prioritize action on human rights related to sexual and reproductive health. For instance, Mexico noted collaborative efforts across sectors in implementing the national strategy to prevent pregnancies among adolescents and the implementation of adolescent-friendly services. Latvia reported that when developing the public health guidelines for 2014–2020 a comprehensive situational analysis had been carried out and gaps had been identified related to maternal and child health. As a result, the Mother and Child Health Improvement Plan 2018–2020 had been developed in cooperation with health professionals and patient representatives.

10. In Uganda, the Ministry of Health has worked together with partners to develop a multisectoral strategy to reduce preventable maternal mortality. The draft strategy, which will be adopted in 2020, includes key recommendations for interlocutors at the national and local levels aimed at the prevention of maternal mortality and morbidity, such as strengthening health systems, establishing a multisectoral response to planning, financing and implementation, and strengthening community engagement, utilizing a human rights-based approach. As part of this commitment, specific focus has also been devoted to the sexual and reproductive health and rights of women living with HIV in Uganda. Through a

sectional study", *BMC Pregnancy and Childbirth* (2020); R. Rima Jolivet and others, "Ending preventable maternal mortality: phase II of a multi-step process to develop a monitoring framework, 2016–2030", *BMC Pregnancy and Childbirth* (2019).

[4] E/C.12/MLI/CO/1, para. 49 (a); CEDAW/C/BFA/CO/7, para. 37 (e); and CEDAW/C/NER/CO/3-4, para. 33 (b).

[5] See https://www2.ohchr.org/english/OHCHRReport2018_2021/OHCHRManagementPlan2018-2021.pdf, p. 22.

[6] See www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf.

[7] See www.government.se/statements/2020/05/joint-press-statement-protecting-sexual-and-reproductive-health-and-rights-and-promoting-gender-responsiveness-in-the-covid-19-crisis/.

multi-stakeholder initiative, organized by OHCHR, together with the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), and with the support of the Ministry of Health, women living with HIV from around the country were brought together to document their human rights concerns in relation to their sexual and reproductive health, including maternal health, and dialogue with duty bearers on potential corrective actions.

B. Legislation, planning and budgeting

11. Ensuring that laws and policies are aligned with human rights standards and adequately resourced is another important component of applying a human rights-based approach. An important first step is to guarantee the right to health, including sexual and reproductive health in law, including through constitutional protections, as exist in many countries.

12. Some States have an established practice of verifying that proposed laws and policies are in line with their human rights obligations. For instance, New Zealand explained its practice of ensuring that all policy proposals leading to legislation must be assessed for consistency with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

13. In undertaking such an alignment exercise, a human rights-based approach influences the content of laws and policies, such as prioritizing a focus on the most marginalized populations. For instance, Australia reported that the technical guidance had informed the development of the National Women's Health Strategy 2020–2030 with respect to addressing core human rights principles, identifying priority areas, including maternal, sexual and reproductive health and the underlying determinants of health, and recognizing priority populations, such as Aboriginal and Torres Strait Islander peoples. Ethiopia highlighted how the Ministry of Health had used the guidance in building consensus at the subnational levels on the importance of using a human rights-based approach in reducing maternal mortality and morbidity and using the available resources to ensure the availability, accessibility, acceptability and good quality of services. Steps taken included focusing on pastoralist regions, which constituted about 20 per cent of the population, to address disparities in, and the availability, access and utilization of, maternal health services, and revitalizing support for health extension programmes in order to reach women and girls living in rural areas where access to maternal health services was more challenging.

C. Programmes and capacity-building

14. Applying a human rights-based approach is also achieved through dedicated programmes to address specific human rights concerns. For instance, building capacity in the application of human rights-based approaches is critical for ensuring that duty bearers have the information and resources they require to meet their obligations. There are also numerous programmes directed towards ensuring the availability, affordability, acceptability and quality of services, as required under human rights law.

15. Nepal reported efforts to build enhanced capacity and understanding of human rights-based approaches, with support from the United Nations, which had led to a commitment to the provision of respectful maternity care as a cornerstone of its health policy. In Uganda, OHCHR had worked with the Ministry of Health to build capacity among local government officials, as well as medical officers, on applying a human rights-based approach, with a focus on maternal health.

16. In Argentina, the Centro de Estudios de Estado y Sociedad[8] and the Access to Safe Abortion Network[9] had, since 2007 and 2011, respectively, organized capacity-building

[8] See www.cedes.org/ (in Spanish).

[9] See www.redaas.org.ar/english.

through an interdisciplinary project developed by a group of lawyers, health professionals, researchers and activists, focused on a human rights-based approach to access safe and legal abortion, which was one of the leading causes of maternal mortality and morbidity in the country. The work, which was still ongoing, had been combined with case-specific legal advice, to enable health professionals to understand better where abortion services were permitted under the current legislation, and also influenced the way health professionals engaged in public discourse concerning the legislative proposal to liberalize the abortion law in Argentina.

17. Marie Stopes International explained how it engaged with health workers on human rights principles through a values-clarification exercise in order to identify potential underlying biases, and put the client at the heart of its programming. With respect to ensuring quality services, Marie Stopes International reported on training conducted in Yemen for government health officers to support the organization in the area of quality assurance for sexual and reproductive health services. That had enabled the organization to maintain high quality standards while also helping to strengthen the health system.

18. Several submissions also highlighted efforts to ensure the affordability of services. For instance, Marie Stopes International had used a voucher programme in Yemen to enable women to access maternal health and contraceptive services. UNFPA explained that in India, there were different safety-net programmes to ensure that the poorest women had access to antenatal and neonatal care. In Burundi, UNFPA had increased the availability of emergency obstetric and newborn care services by providing equipment and training at health facilities.

1. Programmes in humanitarian settings

19. Recognizing that the majority of maternal deaths occur in crisis settings, there has also been dedicated attention to ensuring human rights in these contexts. The Human Rights Council has prioritized this issue, requesting that the United Nations High Commissioner for Human Rights organize a meeting to discuss the issue.[10] As a result of the expert group meeting, efforts are under way to build understanding and capacity to apply human rights-based approaches in these contexts, taking account of their specificities. This includes clarifying what human rights require and dispelling misunderstandings, as well as considering the complicated circumstances that crisis scenarios present that have an impact on the identification of duty bearers, the availability of health services and the existence of accountability mechanisms (see A/HRC/42/24). There has been more of a focus on rights-based approaches to sexual and reproductive health in guidance and policy documents in humanitarian spaces, including *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*,[11] the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, including the Minimum Initial Service Package for sexual and reproductive health,[12] and Economic and Social Council resolution 2019/14, adopted in the context of the humanitarian affairs segment at its 2019 session, in which the Council urged States to ensure reliable and safe access to the services that were important in protecting women and girls from preventable mortality and morbidity that occurred in humanitarian emergencies.

2. Addressing discrimination, and programming for marginalized groups

20. Some stakeholders highlighted health interventions specifically designed to address discrimination and focused on marginalized women and girls who were at high risk of maternal mortality and morbidity. For instance, New Zealand indicated that Maori, Pacific and Asian women were overrepresented in the maternal morbidity statistics compared with non-Maori, non-Pacific and non-Asian women. Both Australia and New Zealand had developed health plans with the aim of addressing inequalities resulting from structural discrimination in the health-care system.

[10] Council resolution 39/10.

[11] See https://spherestandards.org/handbook-2018/.

[12] See https://iawgfieldmanual.com/.

21. Bulgaria reported that women and girls from the Roma community living in remote areas faced a relatively higher risk of suffering from maternal morbidities due to low socioeconomic status, early pregnancy, which was linked to early marriage, and lower levels of education. In that regard, among other initiatives, the State had set up mobile units in remote areas in order to ensure equal access to maternal health care for women and girls from the Roma community.

22. In Uganda, UNFPA had promoted a priority focus on young people's human rights. For instance, by providing teenage mothers with life-skills training and support for re-enrolment at school. It had also worked with WHO to provide adolescent sexual and reproductive health counselling, with a view to preventing unintended pregnancies in Namibia.

D. Monitoring, review, oversight and remedies

23. The technical guidance emphasizes that accountability is central to every stage of a human rights-based approach. Monitoring, review, oversight and remedies are critical components of this understanding of accountability.

24. Monitoring mechanisms are needed to track, analyse and publish disaggregated data and information on maternal health outcomes, including maternal morbidity and maternal mortality.[13] In two countries, UNFPA had focused on supporting accountability by rolling out the technical guidance with the respective national human rights institutions and ministries of health, monitoring violations of sexual and reproductive health and rights, and supporting the systematic process of conducting maternal and perinatal death reviews.[14]

25. To facilitate monitoring, data-collection efforts must be prioritized. For instance, Georgia noted its routine clinical audit of cases of stillbirth and of maternal and neonatal deaths. The comprehensive audit process enabled the identification of gaps and deficiencies in the delivery of care and in the wider health system, which then supported corrective policy and practice measures at the local and national levels. In Yemen, Marie Stopes International had created a mobile application that functioned through text message to enable the collection of crucial data needed to monitor and evaluate services.

26. Human rights fact-finding is another modality for the collection of data on maternal, sexual and reproductive health. For example, in Nigeria, the Center for Reproductive Rights had documented the situation of sexual and reproductive health and rights in the context of conflict. The findings revealed a severe lack of availability and prioritization of sexual and reproductive health services for internally displaced persons, including lack of proper care for pregnant women and a lack of medical attention for nursing mothers. The analysis informed advocacy with the authorities in order to improve health services for women and girls.

27. Inputs received pointed to the role of the courts, as a form of oversight and potential avenue for remedies, in assessing whether existing practice is in line with human rights obligations. In Guatemala, Mayan midwives and indigenous organizations, with support from OHCHR, filed a case before the Constitutional Court calling for the ministry responsible for health to comply with the law in relation to intercultural maternal health. Although Guatemala has a legal framework for the protection of the rights of indigenous women, this was not reflected in the implementation of intercultural public policies related to the work of midwives. In 2019, the Constitutional Court handed down its judgement and called on the State to respect traditions, customs and practices in line with a cultural perspective and without discrimination.

28. Transitional justice mechanisms are also important for ensuring accountability. The Center for Reproductive Rights explained how it was working in Colombia to document human rights violations such as forced abortion, forced sterilization and cases of the control

[13] See submissions from Australia, Bulgaria, Georgia, Italy, Latvia, Mexico, Nepal and New Zealand.

[14] Input provided by UNFPA.

of women's and girls' reproduction during the conflict in order to support the work of the truth commission.

III. Challenges for the implementation of the technical guidance

29. The examples provided above present an encouraging picture regarding the implementation of the technical guidance and human rights-based approaches more broadly. Despite these positive experiences, there are many challenges that hinder further implementation of the guidance and human rights-based approaches. On the basis of the submissions received, the following challenges have been identified: discriminatory laws and practices, difficulties in obtaining quality data, lack of financial and human resources, including specialized health professionals, and lack of awareness and capacity for applying human rights-based approaches.

30. In many places, discriminatory laws and practices continue to hinder the realization of women's and girls' human rights, with a negative impact on their maternal, sexual and reproductive health. For instance, UNAIDS expressed concern that pregnant women living with HIV faced discrimination ranging from denial of health care to stigmatization and, in some cases, institutional violence, all of which were contributors to maternal morbidities and could create a chilling effect on seeking health care when needed. Women Enabled International stressed that women with disabilities could have particularly negative experiences during pregnancy and childbirth, which had a serious impact on their physical and mental health.

31. There are also challenges in accommodating the needs of specific groups. Australia highlighted the challenge of ensuring the availability of culturally appropriate antenatal and postnatal services for Aboriginal and Torres Strait Islanders. Nepal explained that while there were policies responsive to the needs of adolescent girls and women living in rural areas, there remained gaps in implementation and in the availability of resources.

32. Widespread discrimination against women and girls, which manifests in high rates of child, early and forced marriage, female genital mutilation and intimate partner violence, all contribute to poor maternal health outcomes, in addition to violating women's and girls' human rights. Legal barriers, such as third-party authorization requirements or highly restrictive abortion laws, also prevent women and girls from accessing the health care they need, and to which they are entitled. Successfully applying a human rights-based approach to maternal health policies and programmes requires simultaneous action to address entrenched discrimination and promote gender equality. These challenges require persistent, long-term engagement towards social change.

33. Obtaining quality data on sexual and reproductive health, including maternal health, remains challenging. Few countries reported an institutionalized and nationwide process for reporting and reviewing maternal deaths and morbidities. Data on maternal morbidities is especially hard to collect, as further explained later in the present report. Submissions included descriptions of challenges in ensuring consistent data standards with respect to maternal morbidities and the subsequent implementation of standards across all jurisdictions for nationally comparable reporting.[15]

34. A lack of financial and human resources was also highlighted as a major challenge to applying rights-based approaches. In many places, infrastructure constraints and geographical distance to health facilities continued to impede the full implementation of the technical guidance and human rights-based approaches more broadly.[16] Submissions also pointed to shortages of specialized medical personnel and a concentration of available personnel in urban areas, translating into poor coverage for rural populations.[17] Weak health

[15] See submissions from Australia and Paraguay.

[16] See submissions from Azerbaijan, Georgia, Iraq, Italy, Latvia, Mexico and Nepal.

[17] See submissions from Azerbaijan and Nepal, and UNFPA.

systems are also a major factor in undermining maternal health rights, manifested for instance by delays in access to adequate emergency obstetric care.[18]

35. Ensuring that health workers are equipped to apply human rights-based approaches is another difficulty reported. Ethiopia reported that gaps remained in the capacity of health-care professionals in integrating rights into maternal health programming at all levels of the health system. In some places, poor-quality care and biased attitudes of health professionals were signalled as problems for advancing human rights-based approaches.

IV. Maternal morbidity as a human rights issue

A. Overview of maternal morbidities

36. Understanding maternal mortality and morbidity as a matter of human rights requires recognition that the deaths and grievous injuries sustained by women during pregnancy and childbirth are not inevitable events, but rather a direct result of discriminatory laws and practices, failures to establish and maintain functioning health systems and services, and a lack of accountability.

37. Efforts to improve maternal health globally are often focused primarily on measures to avoid maternal death, with less attention devoted to the problem of maternal morbidity. Maternal morbidity is an overarching term that has been defined by the WHO Maternal Morbidity Working Group as "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing".[19]

38. Maternal morbidities vary in duration and severity and cover a broad range of diagnoses requiring a wide variety of treatments.[20] WHO has identified 121 conditions[21] that can be characterized as direct or indirect maternal morbidities, including obstetric-related complications such as prolonged or obstructed labour, complications of unsafe abortion, obstetric haemorrhage and hypertensive disease. If not managed properly, or untreated, these conditions can lead to a variety of outcomes, including issues such as uterine prolapse, obstetric fistula, infertility, incontinence or postpartum depression. Certain risk factors, such as anaemia, HIV, obesity and female genital mutilation, make some women and girls more vulnerable to suffering a maternal morbidity.[22]

39. Precise data on maternal morbidities globally are not available. The fact that data on morbidities is generally unavailable signals that the issue has not been prioritized. The lack of data is also connected to difficulties surrounding the definition and measurement of maternal morbidity, which poses challenges for obtaining comparable data.

40. Although the exact prevalence of maternal morbidity is not known, recent research suggests that global severe maternal morbidity rates are increasing.[23] Maternal morbidities or disabilities are estimated to affect between 15 million and 20 million women worldwide

[18] See submission from UNFPA.

[19] Tabassum Firoz and others, "Measuring maternal health: focus on maternal morbidity", *Bulletin of the World Health Organization* (2013), p. 795.

[20] "Maternal morbidity can be conceptualized as a spectrum ranging, at its most severe, from a 'maternal near miss' – defined by the World Health Organization as the near death of a woman who has survived a complication occurring during pregnancy or childbirth or within 42 days of the termination of pregnancy – to non-life threatening morbidity." Ibid., p. 794.

[21] Doris Chou and others, "Constructing maternal morbidity – towards a standard tool to measure and monitor maternal health beyond mortality", *BMC Pregnancy and Childbirth* (2016).

[22] Robert E. Black and others, *Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, Third Edition* (vol. 2) (Washington, D.C., International Bank for Reconstruction and Development, 2016).

[23] Stacie E. Geller and others, "A global view of severe maternal morbidity: moving beyond maternal mortality", *Reproductive Health*, vol. 15, supplement 1 (2018), pp. 31–32.

each year.[24] For every woman who dies of pregnancy-related causes, it is estimated that 20 to 30 others experience acute or chronic morbidity, often permanent, undermining their health and well-being.[25] Consistent with rates of maternal mortality, maternal morbidity rates are estimated to be highest in low- and middle-income countries, with a higher prevalence of maternal morbidities among marginalized women.

41. Looking only at maternal mortality rates to assess a country's progress in the area of maternal health overlooks the importance of maternal morbidity, which is not only a precursor to maternal mortality but also carries the potential of long-term negative impacts on women's health and quality of life. In the available research, maternal deaths have been described as "the tip of the iceberg and maternal morbidity as the base".[26] A human rights-based approach to maternal health necessitates increased attention to maternal morbidities in order to uphold a wide variety of human rights for women and girls.

B. Maternal morbidity and human rights

42. The impact of maternal morbidity on the human rights of women and girls is significant. Human rights bodies have consistently recognized that maternal health is a matter of human rights, in particular highlighting the rights to health, privacy, education and an effective remedy, as well as the prohibition of discrimination and torture and other forms of cruel, inhumane or degrading treatment, among others. They have also made it clear that maternal health services, which include services to prevent and treat maternal morbidities, must be of good quality, available, accessible and acceptable to all pregnant women and girls, and provided without discrimination. A human rights-based approach to maternal morbidities is premised on the principles of accountability, participation, transparency, empowerment, sustainability, international assistance and non-discrimination. Applying a human rights-based approach to maternal morbidities will (a) support efforts to empower women to claim their rights, (b) address factors such as discriminatory laws, policies and practices, as well as underlying determinants of health, which heighten risks of maternal morbidities, (c) identify gaps in service provision, treatment and prevention, and (d) establish systems of accountability to respond to human rights violations.

C. Maternal morbidities in focus

43. The term maternal morbidity captures a wide range of conditions, which cannot be described in detail in the present report. The four illustrative examples of maternal morbidities listed below are included in the analysis because the human rights dimensions of their causes and consequences are particularly salient. These are also some of the maternal morbidities for which more robust data and research exists, enabling a fuller analysis.

1. Obstetric fistula

44. Obstetric fistula can be a serious and devastating lifelong condition if left untreated, with severe medical, social, psychological and economic consequences. It is described "as an abnormal opening between the vagina and the bladder or rectum, leading to continuous urinary or faecal incontinence".[27]

45. Prolonged, obstructed labour without access to timely, high-quality medical treatment causes the vast majority of obstetric fistula cases worldwide. With access to quality maternal health care, obstetric fistula is largely preventable. It is estimated that,

[24] Marge Koblinsky and others, "Maternal morbidity and disability and their consequences: neglected agenda in maternal health", *Journal of Health, Population and Nutrition*, vol. 30, No. 2 (2012).

[25] Firoz and others, "Measuring maternal health", p. 794.

[26] Ibid.

[27] See www.who.int/reproductivehealth/topics/maternal_perinatal/fistula/en/.

annually, between 50,000 and 100,000 women develop obstetric fistula.[28] Women and girls living with untreated obstetric fistula can risk chronic incontinence, which leads to a range of other physical conditions, including frequent infections, kidney disease, painful sores and infertility. The physical injuries can also lead to social isolation and psychological harm. Affected women are often unable to work, and some are abandoned by their families, thereby deepening their poverty (A/73/285 para. 4).

2. Uterine prolapse

46. Uterine prolapse is another maternal morbidity with serious repercussions for women's lives and well-being. Uterine prolapse occurs when pelvic floor muscles and ligaments stretch and weaken and no longer can support the proper positioning of the uterus. In its most severe stage, the uterus may come out of the vagina completely. The physical symptoms of uterine prolapse depend on the severity of the condition, and can include lower-back pain, abdominal pain, painful sexual intercourse, stress urinary incontinence and discomfort in the pelvic area.

47. A number of factors put women, mostly in developing countries, at risk of this condition, such as higher numbers of births within a short space of time, giving birth at a young age, inadequate nutrition, lack of rest during and immediately after pregnancy and prolonged or difficult labour, including the use of harmful birthing practices.[29] The global prevalence of uterine prolapse is estimated to be anywhere between 2 and 20 per cent among women under the age of 45.[30] In addition to physical discomfort, it can also adversely affect women's mental health by impairing their ability to work and can put them at risk of emotional and physical abuse.

3. Postpartum depression

48. Postpartum depression refers to a nonpsychotic depressive episode that begins in the postpartum period, usually within 1 to 12 months after delivery.[31] Its symptoms include feelings of guilt, anxiety, inconsistent sleeping patterns and fatigue, as well as feelings of being inadequate and unable to cope with the infant, with some women seeing themselves as "bad", inadequate or unloving mothers. A variety of risk factors have been identified as predictors of postpartum depression, which include depression or anxiety during pregnancy, stressful recent life events, poor social support, a previous history of depression, obstetric and pregnancy complications and intimate partner violence.[32]

49. The global prevalence of postpartum depression has been estimated at 100–150 per 1,000 births. Prevalence rates have been found to be even higher in low- and middle-income countries. Shortages of mental health resources, inequities in their distribution and inefficiencies in their utilization are key obstacles to ensuring mental health.[33] Treatment of postpartum depression is challenging, as it often goes undiagnosed. For instance, in many places, women may not participate in postnatal visits; where they do, the focus of the visit

[28] See www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula. It is important to recognize that fistula can also be caused by sexual violence, known as traumatic fistula, which is also a serious human rights concern. See, for example, United Nations Mission in South Sudan and OHCHR, "Access to health for survivors of conflict-related sexual violence in South Sudan" (May 2020), para. 37.

[29] Amnesty International, *Unnecessary Burden: Gender Discrimination and Uterine Prolapse in Nepal* (London, 2014), p. 18.

[30] Karen Hardee, Jill Gay and Ann K. Blanc, "Maternal morbidity: neglected dimension of safe motherhood in the developing world", *Global Public Health*, vol. 7, No. 6 (2012), p. 610.

[31] Donna E. Stewart and others, *Postpartum Depression: Literature Review of Risk Factors and Interventions* (University Health Network Women's Health Program, 2003), p. 21.

[32] Ibid., pp. 2 and 19.

[33] Ravi Prakash Upadhyay and others, "Postpartum depression in India: a systematic review and meta-analysis", *Bulletin of the World Health Organization*, vol. 95, No. 10 (2017). See also Jane Fisher and others, "Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review", *Bulletin of the World Health Organization*, vol. 90, No. 2 (2012).

is often on the newborn's health rather than the mother's, and/or health professionals may lack awareness of the signs and symptoms of postpartum depression.

50. Untreated postpartum depression can have adverse consequences for women, their infants and families. It can be the precursor of chronic recurrent depression and, in severe cases, can lead to suicide. In most societies, mental health problems are stigmatized, which has consequences for many aspects of women's lives, including within the family, in the community and at work. It can also negatively affect the mother-infant relationship and infant development.

4. Infertility

51. Infertility is another condition that can be associated with maternal morbidities, as it can result from complications of unsafe abortion and other maternal morbidities, such as sepsis. Infertility is defined by WHO as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse".[34] WHO has also estimated that 34 million women, mainly from developing countries, have infertility as a result of either maternal sepsis or unsafe abortion.[35] Coercive practices such as involuntary sterilization also lead to infertility, and have been documented particularly among women and girls living with disabilities, women and girls living with HIV, indigenous and ethnic minority women and girls, and women and girls living in poverty.[36]

52. The consequences of infertility can be severe. Women are frequently blamed for fertility issues, regardless of whether the medical issue is actually in their body or their partner's body. They may be stigmatized and alienated from their families and communities, and can also face a higher risk of violence.

D. Human rights causes and consequences of maternal morbidities

1. Gender-based discrimination

53. Gender-based discrimination is both a cause and a consequence of maternal morbidity. The ability of women and girls to make choices about when and with whom they have sex is connected to whether they will go through pregnancy and childbirth safely. Discrimination against women and girls also influences their access to health-care services, or lack thereof.

54. Harmful practices are a violation of human rights that constitute discrimination against women and girls,[37] and they are connected to a higher risk of maternal morbidities. Girls who are victims of child and forced marriage are more likely to have more children and likely have them earlier, which increases their likelihood of suffering a maternal morbidity. Similarly, girls who are forced to undergo female genital mutilation face a higher probability of complications in pregnancy and childbirth, and a particular risk of suffering obstetric fistula. WHO identifies the cessation of harmful practices, and delaying the age of first pregnancies, as fundamental actions for preventing maternal morbidities.[38]

55. A critical part of enabling women and girls to go through pregnancy and childbirth safely is ensuring that they are able to make decisions about their sexual and reproductive health, and that they have access to the information they need to make healthy decisions. Discriminatory laws and practices that undermine women's and girls' abilities to make such decisions, including those based on age or marital status, contribute towards the

[34] See www.who.int/reproductivehealth/topics/infertility/definitions/en/.

[35] Ibid.

[36] OHCHR and others, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (World Health Organization, 2014). See also A/73/161.

[37] Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019) on harmful practices, para. 16.

[38] See www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula.

vulnerability of women and girls to suffering maternal morbidities. Laws that restrict women's sexual and reproductive health and rights, including in relation to family planning and abortion, influence both the risk of morbidity and the chance of post-partum recovery.[39] For instance, restrictive abortion laws lead to higher rates of unsafe abortion.[40] Unsafe abortion is a major contributor to maternal morbidities, with about 7 million women admitted to hospitals annually in developing countries. Following unsafe abortion, women and girls may experience a range of morbidities, such as incomplete abortion, infertility, haemorrhage and infection, with some women experiencing life-threatening complications.[41]

2. Intersectional discrimination and maternal morbidity

56. When women face discrimination, including on the basis of age, socioeconomic status, disability, racial or ethnic background, language, religion, national or social origin, health or other status, they routinely face multiple or intersectional discrimination, which substantially heightens their risk of suffering maternal morbidities.

57. Women who, in addition to facing gender discrimination, are from marginalized groups are generally less likely to have access to adequate health care and timely interventions and services owing to numerous factors, including distance, cost, lack of information or cultural insensitivity. Furthermore, they may also be reluctant to access maternal health care because of language barriers or previous experiences of mistreatment and abuse in health-care settings. Harmful gender stereotypes can render certain groups of women, including women with disabilities, women living with HIV and indigenous and minority women, particularly vulnerable to mistreatment in pregnancy and childbirth, exposing them to potential morbidities.

3. Lack of comprehensive quality sexual and reproductive health information and services

58. Quality sexual and reproductive health services are essential for preventing and treating maternal morbidities. Where health systems lack resources, experience shortages of basic medicines and supplies and lack adequate skilled and specialized health professionals, as is the case in many parts of the world, the potential for maternal morbidities increases. For example, insufficient staff with specialist training to treat certain morbidities can lead to long waiting periods to receive treatment, which can contribute to further complications.

59. Even when health care is available, a lack of information means that many women do not know what health care they can access or what symptoms they need to be alert to. For example, Amnesty International reported that among the women it spoke with in Nepal who had uterine prolapse, the majority had not heard about the condition before they experienced it.[42] Similarly, many women with obstetric fistula in Zimbabwe did not know what they suffered from and struggled to find information about the causes and treatment of their condition.[43]

60. Mistreatment and abuse of women in pregnancy and childbirth can also lead to maternal morbidities (see A/74/137). In some cases, human rights violations within health-care facilities directly cause maternal morbidities, such as where women are forcibly sterilized during labour or other pregnancy-related procedures.[44] Besides having a direct

[39] Veronique Filippi and others, "A new conceptual framework for maternal morbidity", *International Journal of Gynecology and Obstetrics*, vol. 141, No. S1 (2018), p. 7.

[40] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed. (2012), p. 17.

[41] World Health Organization, "Preventing unsafe abortion", fact sheet (2019).

[42] Amnesty International, *Unnecessary Burden*, p. 46.

[43] See submission from Amnesty International.

[44] See, for example, Committee on the Elimination of Discrimination against Women, *A.S. v. Hungary* (CEDAW/C/36/D/4/2004). The Committee found a violation of the Convention on the Elimination of All Forms of Discrimination against Women when a woman was sterilized without her informed consent while undergoing surgery in connection with a miscarriage.

impact on individual women's human rights, such practices also contribute to the risk of maternal morbidities by creating an environment in which women will be less likely to seek out other types of sexual and reproductive health services, including antiretroviral treatment, and more likely to turn to untrained individuals for medical assistance.[45]

4. Underlying determinants

61. The health of women and girls during pregnancy and childbirth is highly affected by social and economic factors, which are further influenced by gender discrimination. A woman's living environment is directly related to her overall health, which is correlated to a likelihood to suffer a maternal morbidity in pregnancy or childbirth.[46]

62. Typically, those living in wealthier households, having higher education or living in urban areas have lower levels of morbidity and higher use of adequate maternal health care than those living in poverty, with less education or living in rural areas. Worldwide, women's low rates of literacy and education are linked to rates of maternal morbidity and mortality and to other indices of maternal health, including fertility rates, utilization of prenatal care, unmet need for contraception and age at first birth.[47] Furthermore, discriminatory practices, such as denying women and girls equal access to food, combined with the reality of food shortages at particular times of year, result in undernourishment or malnutrition, which can lead to a higher risk of poor pregnancy outcomes.[48]

5. Social and economic consequences of maternal morbidity

63. Stigma, shame and isolation are often associated with specific forms of maternal morbidities, and can manifest as ostracization or changes in social status, with adverse effects on women's psychological, economic and social well-being.[49] For example, women who experience obstetric fistula suffer constant incontinence, which often leads to their isolation from their families and communities and results in mental health issues, such as depression and low self-esteem (A/73/285, para. 4). Similar impacts have been documented concerning women who suffer from uterine prolapse.[50] Furthermore, fear of not being understood or being perceived to be "defective" can prevent women with postpartum depression from seeking care. Infertility as a result of complications during pregnancy and childbirth is highly stigmatized maternal morbidity, leading to discrimination, ostracism and even violence. Stigmatization can be extreme in some countries, where infertile women are viewed as a burden on the socioeconomic well-being of a community. This amplifies the guilt and shame felt by the woman.[51] A common thread across various forms of maternal morbidities is that women are blamed for bringing on the conditions on themselves, leading to further stigmatization.

64. Various factors can affect the willingness and ability of women to seek health care, leading to conditions worsening without treatment.[52] For instance, surgical repair can treat most cases of obstetric fistula; however, poverty, social stigmatization, misconceptions about the condition and a lack of surgical capacity make treatment unattainable for most women with fistula.[53]

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[45] Robert Yates, Tom Brookes and Eloise Whitaker, "Hospital detentions for non-payment of fees: a denial of rights and dignity" (Chatham House, 2017), p. 5.

[46] UNDP, "A social determinants approach to maternal health", (2011).

[47] UNFPA, "Rich mother, poor mother: the social determinants of maternal death and disability" (2012).

[48] Isabelle Lange and others, "What maternal morbidities are and what they mean for women: a thematic analysis of twenty years of qualitative research in low and lower-middle income countries", *PLOS ONE* (2019), p. 10; Amnesty International, *Unnecessary Burden*, p. 44.

[49] Lange and others, "What maternal morbidities are", p. 14.

[50] See, for example, Amnesty International, *Unnecessary Burden*.

[51] WHO, "Mother or nothing: the agony of infertility", *Bulletin of the World Health Organization*, vol. 88, No. 12 (2010).

[52] Lange and others, "What maternal morbidities are", p. 15.

[53] See, for example, William Murk, "Experiences with obstetric fistula in rural Uganda", *Yale Journal of Biology and Medicine*, vol. 82, No. 2 (June 2009).

65. The linkages between maternal morbidities and personal economic burdens fall across three areas: "the consequences of a lack of funds to provide and seek care; the encumbering costs of health care; and the implications of illness on earning capacity".[54] Personal finances can act as a barrier to seeking health care for women's morbidities, which can then exacerbate the condition and increases the chance for complications. Financial hardship resulting from onerous expenses for treatment contributes to uncertainty, stigmatization, pain, worry and interrupted treatment.[55]

E. Human rights-based approach to policies and programmes to address maternal morbidity

66. Ensuring women's human rights in relation to maternal health requires more than avoidance of death. Increased attention to maternal morbidities is needed to ensure a more holistic approach to women's health, in line with human rights obligations. High rates of maternal morbidity across the world are a result of multiple factors, which include inequality suffered by women throughout their lifetimes. Applying a human rights-based approach to preventable maternal morbidity should include paying attention to ensuring the availability, accessibility, acceptability and quality of treatment, as well as preventive services and measures; enhanced data collection to understand the scope of the issue; participatory approaches that engage directly with women and girls who are affected; and the strengthening of systems of accountability to address human rights denials. Such an approach would also ensure that attention was systematically paid to discriminatory causes and consequences of maternal morbidities.

67. Many stakeholders have made important efforts to ensure treatment for severe maternal morbidities. These efforts must be encouraged, and more attention is needed to ensure that treatment is reached by all women who need it, without discrimination, with particular focus on accessibility and affordability. It is also vital to ensure that the health workforce is equipped to respond to maternal morbidities, which, considering the vast number of conditions included as morbidities, may require specialist training.

68. In addition to treatment, it is essential for States and other relevant stakeholders to put in place strong, effective and comprehensive prevention measures that explicitly address gender-based discrimination and other determinants of health. With holistic prevention strategies, which would include removing all barriers to comprehensive sexual and reproductive health services, as well as dedicated efforts to ensure women and girls are empowered to claim their rights and access reliable information to make decisions about their health, it is feasible to bring maternal morbidity rates down.

69. Addressing maternal morbidities requires more robust information in order to understand their prevalence and typology, as well as disparities between groups of women and girls. Through human rights analysis, stakeholders can identify and address the reasons behind certain women's heightened inability to access adequate and timely maternal health-care interventions and services, causing complications during pregnancy and childbirth. Obtaining such data requires strong systems for documentation and monitoring, which serve as a basis for corrective action taken through changes in practice, policy or even law reform.

70. To address maternal morbidity from a human rights perspective, it is also critical to engage directly with women and girls in efforts to prevent and treat such morbidities. Through participatory approaches, women will have access to relevant information to enable their decision-making in matters affecting their health, pregnancy and childbirth. Following up with women after childbirth is also important for tracking potential morbidities and increasing the likelihood of treatment. It is also essential to pay special attention to certain groups of women and girls who are more likely to suffer maternal

[54] Lange and others, "What maternal morbidities are", p. 14.

[55] Ibid.

morbidities, by ensuring their voices are part of the development and implementation of programmes and policies related to morbidities.

71. Embracing the concept of a "circle of accountability", States can build in avenues for accountability throughout the policy cycle to address maternal morbidities. This includes clearly identifying who is responsible for what action to uphold human rights, and ensuring that women and girls are aware of where to turn if they suffer morbidities during pregnancy and childbirth. This can be achieved through systems of accountability that cut across spheres, including social, professional, political, legal, judicial and international spheres. Through engagement across diverse accountability mechanisms, information critical for corrective action to address systemic problems is revealed, and individual cases can be identified where remedies may be needed.

V. Recommendations

72. **Stakeholders have undertaken numerous initiatives to implement a human rights-based approach to reducing preventable maternal mortality and morbidity. Assessing the impact of the utilization of the technical guidance and increasing understanding of how human rights-based approaches to maternal mortality and morbidity can be operationalized remains critical. In this regard, it is recommended that the Human Rights Council remain seized of this important issue and continue to receive information on the implementation of the technical guidance.**

73. **The following recommendations are addressed to States and other stakeholders, as relevant:**

(a) **Build recognition, at the national and international levels, that preventable maternal mortality and morbidity is a fundamental human rights issue and enhance understanding among all stakeholders of the indivisibility of all human rights;**

(b) **Disseminate and promote implementation of the technical guidance and associated tools as widely as possible, including to all ministries, in particular ministries of health, and relevant public institutions at all levels, as well as to rights holders, civil society organizations and national human rights institutions working in related areas;**

(c) **Strengthen awareness and build the capacities of various stakeholders, including health workers, policymakers, legislators, national human rights institutions and the judiciary, on the application of rights-based approaches to sexual and reproductive health and rights, by organizing, inter alia, briefings and trainings;**

(d) **Convene and support multi-stakeholder meetings at multiple levels, which involve health workers and marginalized women and girls, to discuss the application of a rights-based approach to sexual and reproductive health and rights, identify opportunities within national-level processes and prioritize concrete areas and plans for action;**

(e) **Ensure coordination of multisectoral and cross-disciplinary processes at the national level in order to achieve a comprehensive approach to sexual and reproductive health and rights, including maternal health, as required by a human rights-based approach;**

(f) **Engage in capacity-building for rights holders to enable them to claim their rights and to participate, and contribute to a culture of accountability for delivering on sexual and reproductive health and rights;**

(g) **Increase awareness and the visibility of maternal morbidity as a human rights concern, including through more dedicated research in this area, allocation of sufficient resources and dedicated efforts to ensure the availability of information, particularly for women and girls, on the causes of specific maternal morbidities and their prevention;**

(h) **Prioritize reliable, transparent and collaborative disaggregated data collection on the availability, accessibility, acceptability and quality of sexual and reproductive health services for all women and girls, in order to support more comprehensive policies to prevent and address maternal morbidities;**

(i) **Ensure that health professionals are equipped to address maternal morbidities, including through training, paying special attention to the situation of marginalized women and girls;**

(j) **Develop comprehensive strategies and programmes for the prevention of maternal morbidity, which should include measures for providing improved knowledge about sexual and reproductive health and rights, including through comprehensive sexuality education, as well as measures to address underlying determinants of health, such as gender discrimination and socioeconomic factors, which render certain women and girls more vulnerable to maternal morbidities;**

(k) **Establish accountability mechanisms at various levels in order to address human rights denials in relation to maternal mortality and morbidity, and sexual and reproductive health and rights more broadly.**