

## **Amnesty International's research findings with regards to the application of human rights-based approach to the implementation of policies and programmes to reduce maternal mortality and morbidity**

*Submission by Amnesty International*

### **Introduction**

The Technical Guidance on the application of human rights-based approach to reduce preventable maternal morbidity and mortality (hereafter referred to as TG) recognises that accountability, including social accountability exercised through civil society and with the active participation of communities and people affected by the health care policies is essential for ensuring efficient health care systems and access to sexual and reproductive health services and information for all.<sup>1</sup> Amnesty International's research and campaigning on the human rights violations behind the lack of access to maternal health services and the human rights impact of criminalization of abortion and conduct during pregnancy in specific countries also contribute to social accountability. Our research was conducted with the participation of women and girls who are rights holders who are affected by the health care policies or the application of criminal law, and their testimonies are central component in our approach. Based on our research findings, we have been campaigning for positive changes in these countries in line with human rights principles and standards and States' obligations under international law.

In this submission, Amnesty International would like to highlight some concerns related to the lack of application of comprehensive human rights-based approach to the prevention of maternal mortality and morbidity, and the provision of sexual and reproductive health services including maternal health care, identified through our country research in diverse contexts in several regions. Among these are the multiple barriers women and girls face in accessing antenatal care, including: lack of privacy, patient confidentiality and informed consent at health facilities<sup>2</sup>; lack of information and knowledge about sexual and reproductive health and rights;<sup>3</sup> and lack of accessibility to health care facilities.<sup>4</sup> In addition, criminalization of abortion and conduct during pregnancy<sup>5</sup> in some countries has a significant negative impact on women's access to sexual and reproductive health care by deterring women from seeking health care and forcing them to resort to clandestine, unsafe abortions. In addition to confronting these barriers and unjust criminalization, successful interventions to reduce maternal mortality and morbidity should take into account broader social contexts and include prevention measures, which address also gender discrimination that often underpins maternal deaths and injuries.<sup>6</sup> Furthermore, where women and girls are provided with opportunities to participate in priority setting, planning, implementation and monitoring of the health care services they use, this results in improved access and health outcomes.<sup>7</sup>

### **Barriers to antenatal health care**

South Africa has unacceptably high rates of maternal mortality,<sup>8</sup> with experts suggesting 60% of maternal

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<sup>1</sup> OHCHR, Human Rights-based Approach to Reduce Preventable Maternal Morbidity and Mortality: Technical Guidance, A/HCR/21/22, paragraph 74 (b). Hereafter referred to as TG.

<sup>2</sup> TG paras 20(c) and 66

<sup>3</sup> TG paras 35

<sup>4</sup> TG para 20(b)

<sup>5</sup> TG para 30

<sup>6</sup> TG paras 13 and 14

<sup>7</sup> TG paras 17, 24, 43, 63 and 67

<sup>8</sup> The country has seen improvements since 2011 but the number of women and girls who are dying during pregnancy or shortly after giving birth has increased dramatically since 2000. Today, the maternal mortality rate stands at 269 deaths per 100,000 live births, far higher than the rate of 38, which the government committed to achieve by 2015.

deaths in the country are avoidable.<sup>9</sup> The government of South Africa has expressed determination to reduce the rate of maternal deaths and already has taken important steps towards that outcome, including through key health policies.<sup>10</sup>

A key intervention has been the significant improvement in the effectiveness of maternal mortality surveillance, with improved data capturing in turn strengthening the recommendations of the National Committee for the Confidential Enquiry into Maternal Deaths (NCCEMD).<sup>11</sup> The reports of this expert Committee provide comprehensive analysis of gaps in health policy implementation, service provision, and identify groups at increased risk. In this regard, there is arguably significant alignment with the TG recommendation that states undertake a systematic review of policy implementation.<sup>12</sup> In turn, the Committee's recommendations have influenced health policies and service delivery. For example, the NCCEMD's 2008-2010 review highlighted that the disproportionately high risk of maternal death for women and girls living with HIV, and recommended the provision of Highly Active Antiretroviral Treatment (HAART) to improve their maternal health outcomes<sup>13</sup> (not only to prevent mother-to-child transmission). Since 2011, pregnant women and girls who are living with HIV or who test positive for HIV during pregnancy are provided with antiretroviral treatment. As a result, the rate of maternal deaths has finally begun to decrease, with maternal deaths linked to HIV falling by 13% in 2011.<sup>14</sup> This policy was strengthened with the announcement that from April 2013 the treatment would take the form of a single pill with reduced side effects, instead of multiple tablets.<sup>15</sup> Other recommendations, to strengthen the delivery of maternal health services through the primary health care system, have similarly been implemented.<sup>16</sup>

The NCCEMD's reports, along with other relevant government data, also identified inequalities in maternal health outcomes and access to health services between South Africa's nine provinces and the 52 health districts. Large disparities include divergent rates of spending on health care provision, with a documented correlation between lower rates of maternal mortality and districts with higher per capita spending on district health services.<sup>17</sup> At the provincial level, varying maternal mortality ratios relating to deaths in health care facilities in 2012/13 highlight a low of "8.7 per 100,000 live births in the Western Cape to 177.9 per 100,000 live births in Limpopo. Mpumalanga was the only province to show an increase in the maternal mortality ratio in health facilities – from 135 in 2011/12 to 175.8 in 2012/13".<sup>18</sup> Significant differences in sexual and reproductive health services and outcomes are also found between provinces, reflected in the varying rates of unplanned pregnancies,<sup>19</sup> teenage pregnancies,<sup>20</sup> and prevalence of HIV.<sup>21</sup> In line with the

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<sup>9</sup> National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) 10<sup>th</sup> Interim Report 2011 and 2012, p. 15.

<sup>10</sup> Including: National Department of Health, Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012-2016; National Strategic Plan for a Campaign on Accelerated Reduction of Maternal And Child Mortality in Africa (CARMMA) 2012; Republic of South Africa Department of Health, PMTCT Guidelines Revised March 2013 (hereafter NDoH PMTCT Guidelines);

<sup>11</sup> NCCEMD 10th Interim Report 2011 and 2012, page 4.

<sup>12</sup> TG para 53

<sup>13</sup> NCCEMD 5th Comprehensive Report 2008-2010

<sup>14</sup> NCCEMD 9th Interim Report 2011

<sup>15</sup> Statement issued by the Minister of Health Dr Aaron Motsoaledi during the announcement of the new tender for antiretroviral drugs ahead of the World AIDS Day, 30 Nov 2012,

<sup>16</sup> Strategic Plan for MNCWH 2012-2016; NSP CARMMA 2012; NSP HIV 2012-16

<sup>17</sup> HST, District Health Barometer 2012/13: Focus on Maternal Mortality, page 32.

<sup>18</sup> HST, District Health Barometer 2012/13, page 81.

<sup>19</sup> Wabiri et al (2013) found nationally only 44.4% of pregnancies were planned, with the lowest rates in KwaZulu-Natal (25.5%). Further, almost 90% of pregnancies of those aged under 20 were unplanned. "Among women with HIV, only 31.7% of pregnancies were planned, compared with 42.1% of those non-infected (P = 0.07)," page 12.

<sup>20</sup> Indicated by the birth rate for girls aged under 18 who gave birth at a health facility, the national average is 8%, "the highest proportion of 2012/13 under-18 deliveries was in the Eastern Cape (EC) (10.3%) and the lowest in Gauteng Province (4.8%)." See also HST, District Health Barometer 2012/13, page 60.

TG (para 41)<sup>22</sup> such inequalities are a concern for Amnesty International. The NCCEMD reviews further highlighted delays in accessing health facilities, both for antenatal care and when needing to give birth.<sup>23</sup> As emphasized by the TG, such delays were viewed by Amnesty International as indicative of a human rights failure.<sup>24</sup>

Antenatal care is free in South Africa's public health system and nearly all pregnant women and girls attend an antenatal clinic at least once during their pregnancy. However, most pregnant women do not access antenatal care until the latter stage of pregnancy.<sup>25</sup> Such delays have been linked to nearly a quarter of avoidable maternal deaths in South Africa.<sup>26</sup> Early attendance at antenatal clinics is particularly important for pregnant women and girls living with HIV.<sup>27</sup> Nearly 30% of pregnant women and girls in South Africa are living with HIV,<sup>28</sup> with research indicating that those living with HIV continue to experience various barriers in accessing antenatal care. Amnesty International undertook research to analyze the cause of delays and failure to seek care, and focused on health districts in two provinces with poor performance indicators in the area of maternal health and access to sexual, reproductive and maternal health services, according to government data.

In 2014, Amnesty International published a report examining some of the barriers to antenatal care faced by women in girls in KwaZulu-Natal and Mpumalanga.<sup>29</sup> A qualitative research methodology was used to ensure the inclusion of individual testimony from women and girls, so policy makers and health care workers can gain insight into why early antenatal care is often inaccessible, and design and implement appropriate policies accordingly.

The report identifies three key barriers that cause delays or avoidance of antenatal care and thus contribute to the high maternal mortality rates in the country.<sup>30</sup> These are:

- **Lack of privacy, patient confidentiality and informed consent at health facilities, especially around the implementation of HIV testing during antenatal care.**<sup>31</sup>

The manner in which health care workers communicate information about the HIV testing process at antenatal clinics leads women and girls to believe that the process is mandatory. This consequence, in conjunction with the impact of HIV-related stigma, and the lack of psycho-social

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<sup>21</sup> HST District Health Barometer 2012 noting: "Districts in socio-economic quintile 5 (highest) appear to have the best access to contraception and quintile 1 (poorest), the worst," page 97; HSRC (2014) review noting that "[g]eographical differences were found by locality type and also by province. Rural informal area residents had a significantly higher HIV prevalence than did urban formal area residents." Noting that this may in part explain the far higher rates of HIV prevalence among black Africans, in that "the findings suggest that black Africans (39.1%) were less likely than all other races (>85%) to live in urban formal areas. Urban informal areas are generally under-resourced and lack some of the basic necessities such as formal housing, water, sanitation, and access to preventive health services." They were also less likely to be married. Page XXV.

<sup>22</sup> TG para 43: "The national plan should address disparities in the substantive enjoyment of sexual and reproductive health rights based on prohibited grounds of discrimination, as well as inequalities in wealth, level of education or area of residence."

<sup>23</sup> NCCEMD 5th Comprehensive Report 2008-2010,

<sup>24</sup> TG para 56, noting "Delays in the decision to seek care or opting out of the health system entirely are treated not as idiosyncratic, personal choices or immutable cultural preferences but as human rights failures".

<sup>25</sup> NDoH National CARMMA Dashboard August 2013; District Health Barometer 2012/13, page 221.

<sup>26</sup> NCCEMD 5th Comprehensive Report 2008-2010, page 20, table 1.29.

<sup>27</sup> Black et al (2009); Laher et al (2012), pages 94-96.

<sup>28</sup> The South African Parent to Mother to Child Transmission Evaluation (SAPMTCTE) 2012.

<sup>29</sup> Amnesty International, "Struggle for Maternal Health: Barriers to Antenatal care in South Africa" (AFR 53/006/2014), <https://www.amnesty.org/en/documents/AFR53/006/2014/en/> (hereafter referred to as Struggle for Maternal Health 2014)

<sup>30</sup> Meeting with senior official from the National Department of Health, September 2014

<sup>31</sup> TG para 20(c) notes that acceptability standard with regard to health facilities, goods and services requires that services "as being designed to respect confidentiality and improve the health status of those concerned". TG para 66 states that "institutions need to be organized and managed to facilitate respect for women's sexual and reproductive health rights, such as provision for privacy and confidentiality," and that "any form of abuse, neglect or disrespect of health system users undermines their rights."

support services, can lead them to delay accessing antenatal care. The design of health facilities and certain clinic procedures and practices, including the handling of patients' files, mean that women's and girls' right to confidentiality regarding their HIV and pregnancy status is often compromised, further deterring visits to clinics for antenatal care.

- **Lack of information and knowledge about sexual and reproductive health and rights, including lack of training on the part of health care workers and lack of patient-friendly services.**<sup>32</sup> Women and girls told Amnesty International that they often have difficulty accessing information about contraception, HIV prevention, the importance of antenatal care, and pregnancy. The findings indicated a failure to ensure that information about sexual and reproductive health and rights is adequately disseminated and that all sections of the population are able to access it. Primary health care clinics were known to be sources of information, but they were seen as unacceptable and avoided. This was due in part to a lack of information and training among health care workers, which sometimes led to poor standards of care for pregnant women and girls.
- **Persistent problems relating to the availability and costs of transport to health care facilities.**<sup>33</sup> Persistent problems with the availability, reliability and affordability of transport to health care facilities, combined with poor road infrastructure, further contribute to women and girls (particularly those in rural areas) delaying or avoiding antenatal care. These delays are exacerbated when they are forced to pay for private transport to reach health facilities during pregnancy and labour because of the lack of ambulances serving their communities.

These barriers are linked to a concerning disconnect between policy development and implementation, across all levels of responsibility, at the national, provincial and district level.<sup>34</sup> For example, in relation to the impact of the shortage of nurses on the acceptability of services, the research highlighted divergent practices in the employment terms and training of health care workers across the provinces.<sup>35</sup> A key recommendation was the need to establish national standards on staffing norms, standards and training requirements for all cadres of health care workers.<sup>36</sup> As noted in the TG, the research required evaluation of the required coordination within and between systems, including the implementation of policies, budgets and programmes.<sup>37</sup>

Amnesty International's report also reflects that barriers are exacerbated for women and girls who experience other challenges, particularly those linked to poverty and gender discrimination that often increase during pregnancy.<sup>38</sup> The report highlighted the need to ensure that all service-users, especially women and girls living in poverty and people living with HIV, are able to participate in design and implementation of policies which affect them, to ensure services are available, accessible, acceptable and quality.<sup>39</sup>

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<sup>32</sup> TG para 35 notes that a national plan to reduce maternal morbidity and mortality "should explicitly include additional actions necessary to enable women to effectively enjoy their sexual and reproductive health, including but not limited to their entitlements to these interventions and medicines", which includes also provision of sexual and reproductive health information and education.

<sup>33</sup> TG para 20(b) notes that ensuring women's right to sexual and reproductive health requires meeting standards with regard to health facilities, goods and services accessibility "in four overlapping dimensions: physical, economic (affordable), non-discrimination, and regarding information".

<sup>34</sup> This issue links with the TG at para 64

<sup>35</sup> AI Struggle for Maternal Health 2014, page 19 and further in Chapter 4.

<sup>36</sup> AI Struggle for Maternal Health 2014, recommendations, page 64.

<sup>37</sup> TG para 64 (a) – (e).

<sup>38</sup> TG para 13 acknowledges that "patterns of maternal mortality and morbidity often reflect power differentials in society" and that measures are required to address the social determinants of women's health and intersectional discrimination manifested in poverty and marginalization that affect women's access to healthcare and enjoyment of their other rights.

<sup>39</sup> AI Struggle for Maternal Health 2014, recommendations, page 63.

As noted above, Amnesty International's approach combines our research with campaigns and human rights education, and seeks to raise awareness of human rights issues within the communities where we work to improve accountability. Amnesty International worked in partnership with community-based organisations and ensured that the findings of the Amnesty International's report were presented back to communities who had participated. A significant result was the shift in perception of maternal health care as an issue of poor service delivery to be endured, to one of human rights, to be challenged.<sup>40</sup> Amnesty International was able to support this process by facilitating meetings between community representatives and health care officials at the district and provincial level. This approach highlights the impact local communities can make when they are empowered to demand accountability, and has led to significant changes on the ground in a number of clinics, including: extended hours for antenatal care, the removal of distinct clinic files for pregnant women living with HIV, and the initiation of planned patient transport between one rural clinic and district hospital. This approach aligns with the TG emphasis on women and girls as active agents,<sup>41</sup> the need for increasing understanding of maternal health as a human rights issue<sup>42</sup> and the need for opportunities for meaningful engagement between decision makers and communities, including the most marginalised.

Recognising, as highlighted in the TG, the importance of ensuring accountability at the national level, in November 2014 AI's report was the subject of questions to the Deputy President in the Parliament of South Africa<sup>43</sup>, and in 2015 AI learned that a high level delegation from the national Department of Health had visited some of the research sites in Mpumalanga province to investigate key issues outlined in the report.

Finally, the AI report emphasised the need for an inter-departmental approach to improving maternal health outcomes in South Africa.<sup>44</sup> A subsequent investigation into *Access to Emergency Medical Services in the Eastern Cape*<sup>45</sup> in 2015 by the South African Human Rights Commission has made similar recommendations. The Commission further made recommendations which supported the findings of Amnesty International's report in relation to transport barriers to maternal health services, the Commission found that a vast number of policies in place did not adequately cater for groups with special needs, including pregnant women."<sup>46</sup>

### **The impact of criminalization on unsafe abortion**

Unsafe abortion is the third leading cause of maternal mortality globally, according to the World Health Organisation's (WHO) estimates.<sup>47</sup> The WHO figures reflect that globally deaths and morbidity resulting from abortion are high in countries where access to abortion is legally restricted.<sup>48</sup>

The application of human rights-based approach to reducing preventable maternal morbidity and mortality requires conducting a situational analysis, which should include also an analysis of the legal framework and

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<sup>40</sup> A critical recommendation of the TG at para 16, noting "...In turn, claims for sexual and reproductive health goods, services and information should be understood by health system users, providers and policymakers as fundamental rights, not as commodities to be allocated by the market or matters of charity."

<sup>41</sup> TG para 17

<sup>42</sup> TG at para 16

<sup>43</sup> 5th December 2014: <http://www.enca.com/south-africa/live-deputy-president-takes-questions-national-assembly>

<sup>44</sup> AI Struggle for Maternal Health 2014, recommendations, page 63.

<sup>45</sup> HEARING REPORT OF THE SOUTH AFRICAN HUMAN RIGHTS COMMISSION INTO ACCESS TO EMERGENCY MEDICAL SERVICES IN THE EASTERN CAPE 24 & 25 March 2015 <http://www.sahrc.org.za/home/21/files/EMS%20Report%202015.pdf>

<sup>46</sup> SAHRC 2015 Executive Summary

<sup>47</sup> WHO and Guttmacher Institute, "Facts on Induced Abortion Worldwide, In Brief", 2012. It is well recognized that criminalization of abortion compels women and girls to undergo illegal abortions and that many of them die as a result of such clandestine and unsafe abortions. WHO, Safe abortion: technical and policy guidance for health systems, second edition, 2012

<sup>48</sup> WHO, Safe abortion: technical and policy guidance for health systems, second edition, 2012

whether it enables the enjoyment of sexual and reproductive health and rights, and ensures substantive gender equality. The TG recognizes that “laws and services that impede access to sexual and reproductive health services must be changed, including laws criminalizing certain services only needed by women; laws and policies allowing conscientious objection of a provider to hinder women’s access to a full range of services; and laws imposing third-party authorization for access to services by women and girls.”<sup>49</sup>

The criminalization of abortion, both in cases of total abortion bans and of highly restrictive abortion laws, is discriminatory and obstructs women and girls’ access to necessary health services, putting their health and lives at risk. This often disproportionately affects women and girls who do not have the means to seek a safe and legal abortion in another country or to pay for expensive illegal abortions in private clinics in the country.<sup>50</sup> Women and girls can also be denied access to health care treatment for serious medical conditions such as cancer or lupus for example on the grounds that treatment may damage the foetus.<sup>51</sup>

Women and girls pregnant as a result of incest or rape are denied legal abortions and compelled to carry pregnancies to term, regardless of their wishes, with negative short and long-term physical and mental health consequences.<sup>52</sup> This happens even in countries where there are exceptions in the law.<sup>53</sup> Multiple human rights treaty bodies have concluded that denying legal abortion to victims of sexual violence violates their right to be free from cruel, inhuman or degrading treatment, as well as their right to redress and reparation.<sup>54</sup>

Women and girls who have undergone unsafe clandestine abortions and seek post-abortion care in the health system are also being reported to law enforcement officials by the health professional and can face criminal charges.<sup>55</sup> In El Salvador, many women serving long-term prison sentences on pregnancy-related charges have been reported by medical providers when seeking medical care for complications of illegal abortion or miscarriages.<sup>56</sup>

The criminalization of abortion also leads to a “chilling effect” on health care providers and deters them from providing post-abortion care, as well as legal abortions due to the fear of criminal prosecution or because they are unclear on how to interpret the law.<sup>57</sup> In Ireland, in addition to criminalizing abortion in most cases, the provision of abortion-related information is also heavily restricted, with a criminal penalty potentially being imposed if the provision of information is deemed to be advocating or promoting

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<sup>49</sup> TG para 30

<sup>50</sup> Amnesty International, “The total abortion ban in Nicaragua: Women’s lives and health endangered, medical professionals criminalized” (AMR 43/001/2009), <https://www.amnesty.org/en/documents/AMR43/001/2009/en/>; Amnesty International, “On the brink of death: Violence against women and the abortion ban on El Salvador” (AMR 29/003/2014), <https://www.amnesty.org/en/documents/AMR29/003/2014/en/>

<sup>51</sup> Amnesty International, “El Salvador: woman denied life saving medical intervention” (AMR 29/001/2013), <https://www.amnesty.org/en/documents/AMR29/001/2013/en/>; Amnesty International, “She is not a criminal: The impact of Ireland’s abortion law” (EUR 29/1597/2015), <https://www.amnesty.org/en/documents/eur29/1597/2015/en/>

<sup>52</sup> Amnesty International, “Chile must provide 11-year-old pregnant rape victim with all options, including abortion” (PRE01/344/2013), <https://www.amnesty.org/en/documents/pre01/344/2013/fr/>; Amnesty International, “Listen to their voices and act: Stop the rape and sexual abuse of girls in Nicaragua” (AMR 43/008/2010), <https://www.amnesty.org/en/documents/amr43/008/2010/en/>

<sup>53</sup> Amnesty International, “Paraguay: Life of a pregnant 10-year-old girl at risk” (AMR 45/1554/2015), <https://www.amnesty.org/en/documents/AMR45/1554/2015/en/>

<sup>54</sup> CAT/C/PER/CO/5-6, par 15; CAT/C/NIC/CO/1 at para 16.

<sup>55</sup> Amnesty International, “The total abortion ban in Nicaragua: Women’s lives and health endangered, medical professionals criminalized” (AMR 43/001/2009), <https://www.amnesty.org/en/documents/AMR43/001/2009/en/>

<sup>56</sup> Amnesty International, “On the brink of death: Violence against women and the abortion ban on El Salvador” (AMR 29/003/2014), <https://www.amnesty.org/en/documents/AMR29/003/2014/en/>

<sup>57</sup> Amnesty International, “The total abortion ban in Nicaragua: Women’s lives and health endangered, medical professionals criminalized” (AMR 43/001/2009), <https://www.amnesty.org/en/documents/AMR43/001/2009/en/>; Amnesty International, “She is not a criminal: The impact of Ireland’s abortion law” (EUR 29/1597/2015), <https://www.amnesty.org/en/documents/eur29/1597/2015/en/>

abortion. This restrictive and punitive legal framework creates a huge obstacle for medical providers to perform timely referrals to safe abortion providers in the UK and result in women having to rely on informal networks or experiencing dangerous delays in accessing necessary health services.<sup>58</sup>

The stigma around abortion and the chilling effect of criminalization of abortion leads to inadequate reporting of maternal mortality and morbidity. For example, whilst data indicates that Chile has one of the lowest maternal mortality rates in the Latin American region,<sup>59</sup> these numbers are likely much higher, but due to the illegal status of abortion the true numbers are not accurately reflected.<sup>60</sup>

### **The impact of criminalization of conduct during pregnancy on access to maternal health care**

In the United States, a number of state laws criminalize pregnant women for their conduct during pregnancy. These laws are inconsistent with a human rights-based approach to the provision of sexual and reproductive health services, and intensify the discrimination and inequality that lie at the root of preventable maternal morbidity and mortality. Punitive laws and policies have consistently been found to impede access to health care services women and girls need and have a right to, thus infringing on the rights to health, information, privacy, equality and non-discrimination, amongst other rights, of pregnant women.<sup>61</sup>

For example, in the state of Alabama, at least 479 women have been charged with the crime of “chemical endangerment” for using a drug while pregnant.<sup>62</sup> This punitive approach does not encourage healthy behaviors, but instead erodes trust in the medical community, and drives women further away from the care and treatment, which they need and to which they are entitled. Such delays in access, or inability to access antenatal care has clear implications for the health of the pregnant woman.

During the multiple interviews conducted by Amnesty International with law enforcement officials<sup>63</sup>, child welfare officials, and health care providers many consistently reported that an additional problem to the chilling effect on women seeking care, is that frequently the law is implemented in ways that disregard women’s right to full and informed consent to medical care. Drug tests conducted on pregnant women in health care settings, often without full and informed consent, are used as evidence of this crime.

Due to discrimination, women in the most marginalized positions such as those living in poverty are consistently documented to already have poorer health outcomes.<sup>64</sup> They are also more likely to be subject to greater policing and surveillance. Criminal laws such as the “chemical endangerment” law amplify the stigma that drives women away from care and frequently impacts on the women most in need of antenatal health care and the services and support necessary to have healthy pregnancies.

### **Gender discrimination as a root cause behind maternal mortality and morbidity**

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<sup>58</sup> Amnesty International, “She is not a criminal: The impact of Ireland's abortion law” (EUR 29/1597/2015), <https://www.amnesty.org/en/documents/eur29/1597/2015/en/>

<sup>59</sup> The average maternal mortality ratio for Latin America and the Caribbean for 2010 was 81 per 100,000 live births. In Chile, the maternal mortality rate was 25 per 100,000 live births, the second lowest ratio after Puerto Rico.

<sup>60</sup> WHO, *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Sixth edition, 2011.

<sup>61</sup> Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, U.N. General Assembly, 66th Sess., 3 August 2011, A/66/254

<sup>62</sup> Ala. Code §26-15-3.2: Chemical Endangerment of Exposing A Child to an Environment in Which Controlled Substances are Produced or Distributed; For information on the documented cases see N. Martin, ‘Take a Valium, Lose Your Kid, Go to Jail’, *Pro Publica*, 2015. Available at [www.propublica.org/article/when-the-womb-is-a-crime-scene](http://www.propublica.org/article/when-the-womb-is-a-crime-scene)

<sup>63</sup> Amnesty International, forthcoming report on criminalization of conduct during pregnancy in the USA, to be released in 2016

<sup>64</sup> World Health Organization, ‘Social Determinants of Health: Key Concepts’, Available at [www.who.int/social\\_determinants/thecommission/finalreport/key\\_concepts/en/](http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/)

The TG acknowledges that “patterns of maternal mortality and morbidity often reflect power differentials in society and the distribution of power between men and women”<sup>65</sup> and that “maternal mortality and morbidity is a product of discrimination against women, and denial of their human rights, including sexual and reproductive health rights.”<sup>66</sup> They also points out that human rights-based approach to reducing preventable maternal morbidity and mortality requires that States take all appropriate measures “to eliminate discrimination against women, including gender-based violence, forced and early marriage, nutritional taboos, female genital mutilation/cutting and other harmful practices.”<sup>67</sup>

Women and girls in Nepal suffer from high rates of uterine prolapse, a form of maternal morbidity.<sup>68</sup> A striking factor about the pattern of uterine prolapse prevalence in Nepal is that it affects relatively young women.<sup>69</sup> In 2014, Amnesty International published a report, which examined the accepted risk factors for uterine prolapse and the reasons for their prevalence in Nepal exposing the strong links between the condition and widespread gender discrimination.<sup>70</sup> Medically established factors which increase the likelihood of a woman developing uterine prolapse include giving birth at a young age, having many children within a short space of time, inadequate nutrition, lack of rest during and immediately after pregnancy and prolonged or difficult labour, including use of harmful birthing practices.<sup>71</sup> Many women and girls in Nepal are exposed to several or all of these.

For Nepali women, gender discrimination is both a cause and a consequence of uterine prolapse. Nepali women experience high rates of uterine prolapse and many experience it at a younger age because gender discrimination in their daily lives exposes them to multiple risk factors for the condition. Gender discrimination limits their ability to control their sexuality and make choices related to reproduction, including use of contraception; to challenge early marriages; to ensure adequate antenatal care; and to access sufficient nutritious food. It also puts them at risk of domestic violence, including marital rape. Women with uterine prolapse are then at risk of suffering further discrimination and gender-based violence because their condition may prevent them from engaging in physically hard work or in sexual activity that is expected of them.

Although the government of Nepal has put in place a number of policies and programmes to address some of the risk factors for uterine prolapse, its response has been government response has predominantly focused on providing treatment – almost exclusively surgery (hysterectomy) for the most severe forms of the condition. However, there is no comprehensive prevention strategy for the condition. Amnesty International, jointly with other NGOs working on uterine prolapse in Nepal, developed an advocacy campaign calling on the government to adopt a comprehensive prevention strategy for uterine prolapse, which includes also measures to addresses gender discrimination and empower women to claim their sexual and reproductive rights, including through recognizing uterine prolapse as a human rights issue and

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<sup>65</sup> TG para 13

<sup>66</sup> TG para 14

<sup>67</sup> TG para 14

<sup>68</sup> The UNFPA estimates that the global prevalence of uterine prolapse is anywhere between 2% and 20% among women below 45 years of age (UNFPA, Quality of life, p.1). Based on studies conducted in Nepal at least 10% of Nepali women experience some form of uterine prolapse and the true figure could be much higher in some areas ( UNFPA, Status of Reproductive Morbidities).

<sup>69</sup> A 2013 UNFPA study of Nepali women who had undergone surgery for uterine prolapse found the median age at which they had first experienced the condition was 26 years (UNFPA, Quality of Life, p.22). Globally, older women, usually above reproductive age, are at greatest risk of getting this condition. UNFPA, Status of Reproductive Morbidities, p.76 “Unlike in the developed world where POP is commonly seen in the postmenopausal age group unrelated to childbirth, POP was found in the younger population” [in Nepal]. The Royal College of Obstetricians and Gynaecologists states that half of women over 50 would have some symptoms of pelvic organ prolapse. RCOG, Information Leaflet, [http://www.rcog.org.uk/files/rcog-corp/2013-03-20\\_Pelvic\\_organ\\_prolapse.pdf](http://www.rcog.org.uk/files/rcog-corp/2013-03-20_Pelvic_organ_prolapse.pdf)

<sup>70</sup> Amnesty International, “Unnecessary Burden. Gender Discrimination and Uterine Prolapse in Nepal” (ASA 31/001/2014), <https://www.amnesty.org/en/documents/asa31/001/2014/en/>

<sup>71</sup> National Medical Standard for Reproductive Health, Volume II: Other Reproductive Health Issues, Family Health Division, Ministry of Health and Population, Kathmandu 2003, part 6 on genital prolapse

educating women and girls, families and communities about the risk factors for uterine prolapse and about women's sexual and reproductive rights. This is in line with the TG's recommendation that a national plan to address preventable maternal mortality and morbidity must "explicitly include additional actions necessary to enable women to effectively enjoy their sexual and reproductive health."<sup>72</sup> The campaign resulted in Nepali government including a section on reproductive health and references to uterine prolapse in its 4<sup>th</sup> Five-Year National Human Rights Action Plan for the period 2014/5 to 2019/20 in July 2014. However, the campaign was temporarily been put on hold in the post-earthquake situation.

### **Recommendations**

Amnesty International encourages the OHCHR in preparing its report pursuant to Human Rights Council's resolution 27/11, to highlight the following policy recommendations to States:

- Remove barriers to antenatal care, including by strengthening the health care systems' ability to provide patient-friendly services based on non-discrimination, respect for patient's confidentiality and informed consent;
- Raise awareness of medical personnel about patients' rights and introduce confidential complaint mechanisms within health care services to address patients' grievances and provide redress in cases of violations of patients' rights;
- Develop programmes to promote safe pregnancies and deliveries, including by addressing the social and economic challenges women and girls face accessing early antenatal care and maternity units / skilled birth attendants;
- Ensure opportunities for equal and meaningful participation of all individuals and communities affected by the health policies and programmes, particularly women and girls, in priority setting, planning, implementation and monitoring of the health care provision;
- Repeal laws that criminalise abortion and the provision of abortion-related information, eliminate all punitive measures for women and girls seeking abortion, and for health care providers and others performing abortions or assisting in obtaining such services where consent is fully given;
- Ensure access to abortion both in law and in practice, at a minimum, in cases where pregnancy poses a risk to the life or to the physical or mental health of a pregnant woman or girl, in cases of severe and fatal fetal impairment, and in cases where the pregnancy is the result of rape or incest;
- Ensure that when abortion is legal, it is available, accessible and of good quality for all women and girls without coercion or discrimination, provided with respect for privacy and confidentiality, and without additional barriers such as the requirement for a third party consent or unregulated conscientious objection;
- Ensure that all laws and practices clearly establish the duty of health care providers to respect patient confidentiality, including by not reporting women and girls suspected of undergoing abortions and those who have had miscarriages to law enforcement authorities;
- Immediately and unconditionally release all women and girls who have been detained or imprisoned in relation to undergoing abortions or for having miscarriages, and drop charges against women and girls whose cases are pending trial;
- Tackle abortion-related stigma and take measures to eliminate gender discrimination and harmful stereotypes about gender roles, which are behind the denial of health services to women and girls.
- Conduct research to measure the human rights impact of criminalizing conduct during pregnancy to determine the extent to which such punitive approaches steer women and girls away from antenatal care and negatively impact maternal and foetal health;

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<sup>72</sup> TG para 35

- Ensure that laws criminalizing conduct during pregnancy comply with international human rights law, in particular that such restrictions are for a legitimate purpose, appropriate to meet that purpose, provided by law, necessary for and proportionate to the legitimate aim sought to be achieved, and not discriminatory;
- Develop comprehensive strategies and programmes for prevention of maternal mortality and morbidity, which include also improve knowledge about sexual and reproductive health and rights, including through comprehensive sexuality education that involves also men and boys, and tackling underlying gender discrimination in society and empowering women and girls to make their own decisions in relation to their sexual and reproductive health.