Comments from the Center for Reproductive Rights in response to the call for submissions from the Office of the High Commissioner for Human Rights on maternal mortality and morbidity in humanitarian settings
February 1, 2018

The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception twenty-five years ago, the Center has advocated for the realization of women and girls’ human rights on a broad range of issues, including on the right to access sexual and reproductive health services; preventing and addressing sexual violence; and the eradication of harmful traditional practices, including child marriage. We are pleased to provide this submission to the Office of the High Commissioner for Human Rights on good practices and challenges in the application of a human rights-based approaches to the elimination of preventable maternal mortality and morbidity.

This submission provides an overview of maternal morbidity and mortality in humanitarian settings and discusses how human rights legal obligations and principles provide critical guidance for reducing maternal morbidity and mortality in those settings.

I. Overview of Maternal Morbidity and Mortality in Humanitarian Settings

While there continues to be a need for more reliable data on maternal mortality and morbidity in humanitarian settings, there is little doubt that humanitarian crises exacerbates maternal mortality. In 2015, a United Nations (UN) inter-agency report found that in countries designated as fragile states, the estimated lifetime risk of maternal mortality is 1 in 54, as compared to 1 in 180 global lifetime risk. Maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict.

Studies have found that MMRs among refugees receiving humanitarian aid tend to be lower than among the host population or country of origin, and that delays in seeking and receiving care are among the most significant factors in maternal deaths—factors that are likely exacerbated for asylum seekers in transit. A recent study conducted among Syrian refugee women in Lebanon, for example, found that many women experienced or perceived challenges in accessing reproductive health services, primarily due to costs, distance or transport to facilities, or fear of mistreatment, with more than 35 percent reporting problems during pregnancy or complications during labor, delivery, or abortion.

Lack of reproductive health services includes lack of access to contraception and abortion services and can also be linked to high rates of maternal morbidity and mortality. According to a global evaluation by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), the provision of contraception, particularly long-acting methods and emergency contraception, continues to lag behind in reproductive health services in emergencies. Globally, unsafe abortion accounts for between 8 to 18 percent of maternal deaths, almost all of which occur in developing countries.
Despite recent increased attention to maternal mortality, there has been much less attention and data collection on the global occurrence of non-fatal health outcomes associated with pregnancy and childbearing. More data is needed on both mortality and morbidity, especially in humanitarian settings.  

II. Legal Framework

There are multiple, complementary bodies of law that address the right to safe pregnancy and abortion. International legal bodies have affirmed that fundamental human rights obligations, including those relevant for preventing maternal morbidity and mortality, continue to apply in humanitarian settings. Although international human rights law (IHRL) permits states to derogate from certain civil and political rights in times of armed conflict and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability, human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum core obligations are non-derogable. Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.

Sexual and reproductive health and rights (SRHR), including the right to safe pregnancy and childbirth, are central to the realization of fundamental human rights, including the rights to life, health, freedom from torture and ill-treatment, privacy, education, and non-discrimination, among others. Human rights bodies consistently have emphasized that states’ obligations to guarantee SRHR require ensuring women and girls have access to comprehensive reproductive health information and services. As with other fundamental human rights obligations, obligations related to SRHR continue to apply in humanitarian settings.

For women and girls who decide to carry a pregnancy to term, IHRL obligates states to ensure that women can survive pregnancy and childbirth, including by ensuring their access to adequate pre- and post-natal care, emergency obstetric services, and skilled birth attendants. Human rights bodies have provided detailed guidance on women and girls’ right to maternal health care, which encompasses the full range of services in connection with pregnancy and the post-natal period and the ability to access these services free from discrimination, coercion, and violence.

In humanitarian settings, the CEDAW Committee has explicitly called on states to ensure access to “maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care . . . complications of delivery or other reproductive health complications, among others.” In its recommendations to specific states, the CEDAW Committee has noted with concern the effects of humanitarian crises on SRHR and maternal mortality, in particular, calling on states affected by conflict to “accord priority to the provision of sexual and reproductive health services.” The Committee on Economic, Social, and Cultural Rights (CESCR Committee) considers the obligation to ensure reproductive and maternal health care to be comparable to a minimum core obligation with which states must comply at all times.
Particularly, making contraception and safe legal abortion readily available in humanitarian settings is important for reducing maternal mortality and morbidity. International human rights treaty monitoring bodies have found that all individuals, including adolescents and youth, have the right to access contraceptive information and services as a means of preventing pregnancy and sexually transmitted infections. The CEDAW Committee has recognized that women often experience increased sexual violence in conflict, “which require[s] specific protective and punitive measures,” and has explicitly called on states to ensure access to contraception, including emergency contraception, in humanitarian settings.

Additionally, international human rights treaty bodies and experts have consistently found that denying access to abortion or imposing barriers to access undermines women’s reproductive autonomy and creates circumstances in which women and girls are at a heightened risk for maternal morbidity and mortality. At minimum, states must ensure that abortion is both legal and accessible when a woman’s life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal anomalies and provide humane, quality post-abortion care to women, regardless of whether abortion is legal. Human rights treaty bodies have raised concerns, in particular, about women raped in armed conflict and have found that the denial of safe abortion care to survivors of rape in armed conflict violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment. Human rights bodies have urged states to interpret exceptions to restrictive abortion laws broadly to consider, for example, mental health conditions as a threat to women’s health, as per the World Health Organization’s definition of health.

International humanitarian, criminal, and refugee laws place further obligations on states to address sexual and reproductive health. These laws are especially relevant for women and girls in humanitarian settings, because they contain provisions relevant to maternal morbidity and mortality. For instance, at minimum, international humanitarian law establishes an obligation to provide medical care and attention to pregnant women and victims of sexual violence. International refugee law also includes protections relevant to women and girls in humanitarian settings. The 1951 Refugee Convention protects the rights of refugees to fundamental human rights, including the right to education, access to justice, and employment. International criminal law has also evolved to contain provisions relevant to SRHR for women and girls in humanitarian settings, specifically with regard to sexual violence arising out of conflict. Thus, the multiple bodies of law that protect the rights of women and girls to safe pregnancy and childbirth must be implemented and states must be held accountable for these obligations.

III. Human Rights Based Approach in Sexual and Reproductive Health Service Delivery in Humanitarian Settings

Humanitarian organizations play a significant role in fulfilling the human rights obligations detailed above, especially where state institutions are weakened, overwhelmed, or not functioning. In fulfilling obligations, organizations should adopt a human rights-based approach, as it is critical for ensuring that humanitarian funding, programs, and policies are driven by, benefiting, and accountable to the individuals most directly affected by them.
More specifically, principles of non-discrimination and equality are core tenants of a human rights-based approach and are central to ensuring that humanitarian programs and policies recognize and address the root causes of maternal mortality and morbidity in fragile and humanitarian settings.\textsuperscript{41} Implementing organizations should ensure that affected individuals participate in, shape, and make decisions regarding programs and policies that are intended to be for their benefit.\textsuperscript{42} This is especially important for reducing maternal morbidity and mortality.

Effective accountability mechanisms are another integral part of a human rights-based approach, as they require participation and transparency as well as the ability to confer meaningful and effective remedies to for violations of human rights, including preventable maternal mortality and morbidity.\textsuperscript{43} While the coverage of SRH services in crisis settings has improved in recent years, there remain significant gaps in the comprehensive and systematic delivery of these services.\textsuperscript{44} Meaningful and effective, human rights-based accountability is one tool that can be used to help increase effective delivery of sexual and reproductive health services. A human rights-based approach to accountability recognizes that:

- users of services must be at the center of the design and implementation of crisis response, and should be part of the monitoring to ensure that human rights based services are being implemented;
- complaint mechanisms and remedies must be available and known to users of sexual and reproductive health services who have been harmed; and
- facilities, information and services themselves must be accessible, acceptable, available, and of good quality on a basis of equality and without coercion or violence.

Women and girls in humanitarian settings face limited access to reproductive health care, which puts them at increased risk of maternal morbidity and mortality. Despite some improvements in recent years, there remain significant gaps in care. Yet, women and girls in humanitarian settings are protected by multiple international legal frameworks, which continue to apply in humanitarian settings and provide important and detailed protections related to SRHR that complement and reinforce obligations under international law. Thus, it is critical for states, including those experiencing humanitarian crises, those hosting refugees, and donor states, to prioritize SRHR by ensuring access to maternal health care, contraception, safe abortion care, post-abortion services, and remedies for violations in these settings. All service providers, including UN agencies and humanitarian organizations, should aim to ensure that programs and policies are developed, implemented, and monitored in accordance with human rights and that systems for meaningful and effective accountability to affected women and girls have been fully implemented. For further information, see the Center’s 2017 Briefing Paper, *Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict* (annex 1\textsuperscript{45}). Also, Rebecca Brown, Director of Global Advocacy, can be reached at rbrown@reprorights.org.

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Noting that the Covenant’s obligations continue to apply in situations of armed conflict, The CESCR Committee has recommended that states increase efforts to ensure sexual and reproductive health services for populations affected by conflict or displacement. CESCR, Gen. Comment No. 14, supra note 14, paras. 40, 65 (affirming applicability of Covenant in conflict setting situations and state obligations to ensure minimum essential levels of Covenant rights); CESCR, Gen. Comment No. 3, supra note 13, para. 10; CESCR, Concluding Observations: Israel, paras. 19, 31, U.N. Doc. E/C.12/1/Add.90 (2003); CESCR, Concluding Observations: Nepal, para. 45, U.N. Doc. E/C.12/NPL/CO/2 (2008) (regarding the right to health more generally).


For instance, the CEDAW Committee called on the Congo to “improve the availability of sexual and reproductive health services, including family planning, also with the aim of preventing early pregnancies and clandestine abortions.” CEDAW Committee, Concluding Observations: Democratic Republic of the Congo, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006). See also CEDAW Committee, General Recommendation No. 30, supra note 21, at para. 52(c); CEDAW Committee, Concluding Observations: Central African Republic, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).


CEDAW Committee, Concluding Observations: Central African Republic, para. 40(b), U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); The CEDAW Committee also raised concerns about the restrictions imposed by the Syrian government that have forced women to give birth in unsafe conditions and recommended that the state “prioritize access to maternal health care services, including skilled delivery services for pregnant women irrespective of their area of residence.” CEDAW Committee, Concluding Observations: Syria, para. 40, U.N. Doc. CEDAW/C/SYR/CO/5 (2006).


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In its recommendations to Syria, the CEDAW Committee urged the state to “[e]xpend the grounds on which abortion is permitted to include, in particular, cases of rape, and prepare guidelines on post-abortion care to ensure that women who are pregnant as a result of rape have free access to safe abortion services.” CEDAW Committee, Concluding Observations: Syria, para. 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014). See also CEDAW Committee, Concluding Observations: Democratic Republic of the Congo, para. 32(e), U.N. Doc. CEDAW/C/DRC/CO/6-7 (2013); Human Rights Committee, Concluding Observations: Democratic Republic of the Congo, paras. 13-14, U.N. Doc. CCPR/C/DRC/CO/3 (2006).


In fact, both IHL and IHRL envision a key role for aid organizations. IHL obligates parties to a conflict and third states to facilitate the passage of humanitarian relief to civilians in need. See ICRC, Customary IHL Database, Rule 55, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule55 (last visited May 31, 2017). See also CESCR, Gen. Comment No. 14, supra note 14, para. 65 (recognizing the important role of UN agencies in providing access to basic goods and services in humanitarian settings); SR Health Report (2013), supra note 1, para. 60.

41 Cf. OHCHR, Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies, para. 21, U.N. Doc. HR/PUB/06/12 (2006) (noting, in the poverty reduction context, that an approach based on these principles shifts focus from ‘narrow economic issues towards a broader strategy that also addresses the socio-cultural and political-legal institutions which sustain the structures of discrimination’); see also UNFPA, The Human Rights-Based Approach, supra note 40.


