

# MATERNAL MORTALITY AND MORBIDITY



**In 2015, an estimated 303,000 women died during or immediately following pregnancy and childbirth.**

According to the World Health Organization, *“The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries. There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural and urban areas.”*<sup>1</sup>

A maternal death is “the death of a woman while pregnant or within 42 days of termination of pregnancy... from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”<sup>2</sup> The major complications that account for 75% of maternal deaths are severe bleeding, infection, unsafe abortion, high blood pressure, and prolonged or obstructed labour. Most maternal deaths can be prevented through effective interventions and care during pregnancy and delivery.<sup>3</sup>

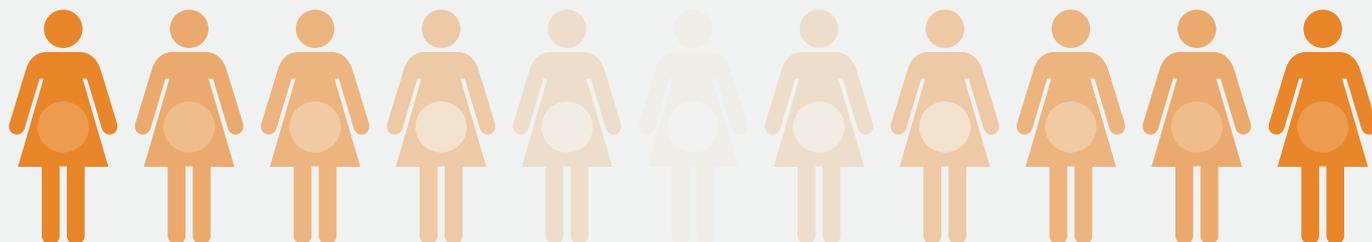
Often seen as a public health concern, the issue of maternal mortality and morbidity must also be understood as a matter of human rights. International human rights treaty bodies have clarified States’ obligations concerning maternal mortality and morbidity and recognized that maternal deaths can amount to violations of women’s rights to life,<sup>4</sup> to the highest attainable standard of health, and to equality and non-discrimination.<sup>5</sup>

Under the Convention on the Elimination of All Forms of Discrimination against Women, “States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary.”<sup>6</sup> The Committee on the Rights of the Child has indicated that “lack of access to such services contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth.”<sup>7</sup> Thus, States should provide adolescents access to free and confidential sexual and reproductive health services, including maternal care services.<sup>8</sup>

The Committee on Economic, Social and Cultural Rights has considered that States’ obligations under the Covenant include the obligation to “ensure reproductive, maternal (pre-natal as well as post-natal) and child health care.”<sup>9</sup> According to the Committee, “lack of emergency obstetric care services or denial of abortion often leads to maternal mortality and morbidity, which in turn constitutes a violation of the right to life or security, and in certain circumstances can amount to torture or cruel, inhuman or degrading treatment.”<sup>10</sup>

Reducing maternal mortality and morbidity remains at the center of national and international commitments. At the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, States recognized the right of women to safe pregnancies. In Sustainable Development Goal (SDG) 3, States have committed to reduce the maternal mortality ratio (from currently 216) to less than 70 per 100,000 live births by 2030.

In 2012, the United Nations High Commissioner for Human Rights developed technical guidance offering concrete advice to States and other stakeholders on what human rights would require at different stages in the policy cycle aimed at reducing maternal mortality and morbidity.<sup>11</sup>



EVERY DAY APPROXIMATELY 830 WOMEN DIE FROM PREVENTABLE CAUSES RELATED TO PREGNANCY AND CHILDBIRTH

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99% OF ALL MATERNAL DEATHS OCCUR IN DEVELOPING COUNTRIES

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

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

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BETWEEN 1990 AND 2015, MATERNAL MORTALITY WORLDWIDE DROPPED BY 44%

Sources: World Health Organization, Maternal Mortality, Key Facts (2018); World Health Organization, Preventing Unsafe Abortion, Key Facts (2018); Every Woman Every Child, The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

**ESTIMATES OF MATERNAL MORTALITY RATIO AND MATERNAL DEATHS IN 2015**

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

REGION	MATERNAL MORTALITY RATIO	NUMBER OF MATERNAL DEATHS
Northern Africa	70	3 100
Sub-Saharan Africa	546	201 000
Eastern Asia	27	4 800
Southern Asia	176	66 000
South-eastern Asia	110	13 000
Western Asia	91	4 700
Caucasus & Central Asia	33	610
Latin America & Caribbean	67	7 300
Oceania	187	500
<b>WORLD</b>	<b>216</b>	<b>303 000</b>

*Source: World Health Organization and others, Trends in Maternal mortality: 1990 to 2015, p.18.*

AT THE REGIONAL LEVEL, RECOGNIZING THE CONTINUED HIGH PREVALENCE OF MATERNAL MORTALITY AND MORBIDITY, THE REVISED MAPUTO PLAN OF ACTION 2016 – 2030, AIMS AT ENDING

*“preventable maternal, newborn, child and adolescent deaths by expanding contraceptive use, reducing levels of unsafe abortion, ending child marriage, eradicating harmful traditional practices including female genital mutilation and eliminating all forms of violence and discrimination against women and girls and ensuring access of adolescents and youth to SRH by 2030 in all countries in Africa.”<sup>12</sup>*



KEY ISSUES

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

*A functioning health system requires adequate supplies, equipment, and infrastructure, as well as an efficient system of communication, referral and transport.<sup>13</sup>*

Under the right to health, women are entitled to services which reduce maternal mortality and morbidity, including access to skilled attendance at birth, emergency obstetric care, post-partum care, safe abortion services, and other sexual and reproductive health-care services, free from coercion, discrimination or violence.<sup>14</sup>

Humanitarian settings and situations of conflict, post-conflict and disaster, which lead to a breakdown in health systems, significantly hamper progress in maternal mortality reduction. More than half of maternal deaths occur in fragile and humanitarian settings.<sup>15</sup> The Committee on the Elimination of Discrimination against Women has urged States “to accord priority to the provision of family-planning and sexual and reproductive health information and services, within disaster preparedness and response programmes” and “reduce maternal mortality rates through safe motherhood services, the provision of qualified midwives and prenatal assistance.”<sup>16</sup> The Human Rights Committee, commenting on the right to life, has emphasized that the “State parties should also develop strategic plans for advancing the enjoyment of the right to life, which may comprise measures to ensure access to treatments designed to reduce maternal and infant mortality.”<sup>17</sup>

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

Regarding the role of private health providers, States “cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies.”<sup>18</sup> In *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, a landmark case on maternal mortality, the Committee on Elimination of Discrimination against Women stressed that the State is directly responsible for the actions of private medical institutions, and that it maintains a duty to regulate and monitor private health-care institutions in line with its due diligence obligations.<sup>19</sup>

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

*Discrimination exacerbates pre-existing inequalities which prevent women from accessing the services they require.*

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

When high rates of maternal mortality and morbidity are attributable to government's failure "to use its available resources to take measures necessary to address the preventable causes of maternal death and ensure availability, accessibility, acceptability and good quality of services,"<sup>20</sup> this is a manifestation of discrimination against women and must be redressed immediately. Persistently high rates of maternal mortality reflects as well a lack of investment in and underprioritization of services required only by women.<sup>21</sup>

Poverty, income inequality and gender discrimination affect women's enjoyment of their sexual and reproductive health and rights.<sup>22</sup> To address this, the Committee on Economic, Social and Cultural Rights has emphasized that "health facilities, goods and services

must be affordable for all," including for socially disadvantaged groups.<sup>23</sup> States should provide free services to women living in poverty during pregnancy, delivery and post-partum periods.<sup>24</sup>

*Restrictive abortion laws lead to higher rates of unsafe abortion, which contributes to maternal mortality.*

As unsafe abortion is one of the five major causes of maternal death, part of protecting women's rights in this area is about ensuring access to safe abortion.<sup>25</sup> The Special Rapporteur on extrajudicial, summary or arbitrary executions has considered that maternal deaths resulting from a "deliberate denial of access to life-saving medical care because of an absolute legal ban on abortion" may constitute gender-based arbitrary killings.<sup>26</sup>

The Committee on Economic, Social and Cultural Rights has emphasized that "to lower rates of maternal mortality and morbidity requires emergency obstetric care and skilled birth attendance, including in rural and remote areas, and prevention of unsafe abortions."<sup>27</sup>

### IN THE CASE OF THE XÁKMOK KÁSEK INDIGENOUS COMMUNITY,

one of the victims was an indigenous woman who had died from complications while in labor and had not received medical attention. The Inter-American Court of Human Rights declared that the State had violated the right to life "because it failed to take the required positive measures, within its powers, that could reasonably be expected to prevent or to avoid the risk to the right to life."<sup>28</sup>

The provision of maternal health services is comparable to a core obligation under the right to health which cannot be derogated from under any circumstances. States need to ensure the availability, accessibility, acceptability and good quality of sexual and reproductive health services, including their affordability.<sup>29</sup>



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

*Maternal mortality and morbidity disproportionately affects rural women and girls.*

In 2016, the Committee on the Elimination of Discrimination against Women highlighted the disproportionately high prevalence of maternal mortality in rural areas, which it attributed to many factors including a lower presence of skilled birth attendants and medical personnel, leading to poor pre- and postnatal care.<sup>30</sup> The Committee also noted a "higher unmet need for family planning services and contraception due to poverty, lack of information and limited availability and accessibility of services. Rural women are also more likely to resort to unsafe abortion than their urban counterparts."<sup>31</sup>

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

The Committee on the Elimination of Discrimination against Women has emphasized the linkages between discrimination on the basis of sex and other factors such as race, ethnicity, religion or belief, health status, age, class, caste, sexual orientation and gender identity.<sup>32</sup> Human rights bodies have recommended that States adopt measures to address maternal mortality and morbidity among marginalized groups,<sup>33</sup> including adolescents,<sup>34</sup> women and girls living in poverty, indigenous women,<sup>35</sup> minority women,<sup>36</sup> and migrant girls.<sup>37</sup>

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

**RESPECT** The Committee on the Elimination of Discrimination Against Women has observed that “laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures” are a violation of the States’ obligation to refrain from interfering with the enjoyment of women’s right to health.<sup>38</sup>

**PROTECT** States are responsible for exercising due diligence, or acting with a certain standard of care, to ensure that non-governmental actors, including private service providers, insurance and pharmaceutical companies, and manufacturers of health-related goods and equipment, as well as community and family members, comply with human rights standards related to sexual and reproductive health and rights.<sup>39</sup>

**FULFIL** States should adopt legislative, administrative, budgetary, judicial, and other measures to prevent maternal deaths and injury. States’ failure to reduce maternal mortality may breach their obligation to ensure women’s access to health care.<sup>40</sup>



## NOTES

- 1 Maternal Mortality, Key Facts (2018).
- 2 World Health Organization, International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, vol. 2, Instruction Manual, 2nd ed. (2004), pp. 98-99.
- 3 World Health Organization, Maternal Mortality, Key Facts (2018).
- 4 Human Rights Committee, General Comment 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life, para. 8.
- 5 Committee on the Elimination of Discrimination against Women, *Alyne da Silva Pimentel v. Brazil*, CEDAW/C/49/D/17/2008 (2011), paras. 7.4, 7.7.
- 6 Article 12(2).
- 7 General Comment 20 (2016) on the implementation of the rights of the child during adolescence, para. 59.
- 8 *Ibid.*, para 59.
- 9 General Comment 14 (2000) on the right to the highest attainable standard of health, para. 44(a).
- 10 General Comment 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 10.
- 11 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, A/HRC/21/22 (2012).
- 12 African Union Commission, *Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights* (2016), p. 2.
- 13 Working Group on the issue of discrimination against women in law and in practice, A/HRC/32/44 (2016), para. 38.
- 14 A/HRC/21/22, para 33.
- 15 World Health Organization, Maternal Mortality, Key Facts (2018).
- 16 General Recommendation 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change, para. 68 (d).
- 17 General Comment 36, para. 26.
- 18 Committee on the Elimination of Discrimination against Women, General Recommendation 24 (1999) on women and health, para. 17; Committee on Economic, Social and Cultural Rights, General Comment 14, para. 35.
- 19 *Alyne da Silva Pimentel v. Brazil*, para. 7.5.
- 20 United Nations Office of the High Commissioner for Human Rights, *Preventable maternal mortality and morbidity and human rights*, A/HRC/14/39 (2010), para. 10.
- 21 A/HRC/32/44, para. 29.
- 22 A/HRC/21/22, para. 13.
- 23 General Comment 14, para. 12(b).
- 24 Committee on the Elimination of Discrimination against Women, General Recommendation 24, para. 27.
- 25 United Nations Office of the High Commissioner for Human Rights, *Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity*, A/HRC/18/27 (2011), para. 25.
- 26 A/HRC/35/23 (2017), para. 94.
- 27 General Comment 22, para. 28.
- 28 Inter-American Court of Human Rights, *Case of the Xákmok Kásek Indigenous Community* (2010), para. 234.
- 29 Committee on Economic, Social and Cultural Rights, General Comment 22, paras. 12-21; General Comment 14, paras. 44(a), 12(b); Committee on the Elimination of Discrimination against Women, General Recommendation 24, para. 21.
- 30 General Recommendation 34 (2016) on the rights of rural women, para. 38.
- 31 *Ibid.*
- 32 General Recommendation 28 (2010) on the core obligations of States Parties under article 2 of the Convention, para. 18; *Alyne da Silva Pimentel v. Brazil*, para. 7.7.
- 33 Committee on Economic, Social and Cultural Rights, General Comment 22, para. 30.
- 34 Committee on the Rights of the Child, General comment 20, para. 59.
- 35 Special Rapporteur on the rights of indigenous peoples, A/HRC/30/41 (2015), para. 33; A/HRC/32/44, para. 54.
- 36 *Alyne da Silva Pimentel v. Brazil*, para. 7.7.
- 37 Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families, General comment 2 (2013) on the rights of migrant workers in an irregular situation and members of their families, para. 72; A/HRC/32/44, para. 50.
- 38 General Recommendation 24, para. 14.
- 39 A/HRC/21/22, para. 22.
- 40 Committee on the Elimination of Discrimination against Women, General Recommendation 24, para. 17; Committee on Economic, Social and Cultural Rights, General Comment 14, para. 33.