

**Submission to the Office of the High Commissioner for Human Rights
Sexual Rights Initiative
February 2020**

1. This submission is made by the Sexual Rights Initiative (SRI).¹ SRI is a coalition of national and regional organizations based in Canada, Poland, India, Argentina, Egypt and South Africa, that work together to advance human rights related to sexuality, gender and bodily autonomy at the United Nations.

Introduction

2. The Millennium Development Goals² (MDGs) and subsequent Sustainable Development Goals³ (SDGs) rightly highlighted the need for adequate and effective state response to prevent and eliminate preventable maternal mortality and morbidities. The inadequate attention paid to women's and girls' health is evidenced by the fact that 15 years of implementation failed to achieve the targets in the MDGs vis-à-vis maternal mortality.⁴ The persistent high rates of maternal mortality and morbidities represent a failure of states to realise the rights related to bodily autonomy and sexual and reproductive health and rights of everyone. While interventions and services needed to combat maternal mortality do exist, "there is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal mortality".⁵ Feminist organising across the world and human rights mechanisms including Special Procedures, Treaty Monitoring Bodies and the Office of the High Commissioner for Human Rights continuously advocated that policy and programmes on Maternal Mortality be rooted in human rights principles including accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination.⁶
3. Despite progress and development, maternal morbidities are often neglected in discussions, policy and programmes. For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that undermine their normal functioning.⁷ It is complex and multidimensional with long-term impacts on women's health and lives and there is an urgent need for programmes to address both maternal mortality and morbidity. Policy and programmes whose sole objective is to reach targets for maternal mortality without morbidity-related objectives and targets will be inadequate and myopic and undermine women's human rights.

¹ <http://www.sexualrightsinitiative.com/>

² MDG Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

³ SDG Goal 3 includes a target of Reducing the global MMR to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average".

⁴ According to the World Health Organization, about 295 000 women died during and following pregnancy and childbirth in 2017. <https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality>

⁵ A/61/338, para. 9; United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

⁶ United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, para 32 <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

⁷ World Health Organization, <https://www.who.int/bulletin/volumes/91/10/13-117564/en/>

4. Maternal morbidity is an overarching term that has been defined as “any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing.”⁸ These are not necessarily life-threatening but can have a significant impact on the quality of life.⁹ It is defined as “a condition outside of normal pregnancy, labour, and childbirth that negatively affects a woman’s health during those times.”¹⁰ As Koblinsky et al. point out,

“[a]cute maternal morbidities include various terms, such as ‘obstetric complications’, ‘maternal complications’, ‘absolute maternal indications’ (AMIs), ‘severe acute maternal morbidities’ (SAMMs), and ‘near-miss’ and typically refers to acute problems suffered during pregnancy through the standard postpartum period of 42 days. Obstetric or maternal complications are acute conditions that may directly cause maternal deaths. According to the United Nations Children’s Fund/WHO/United Nations Population Fund (1997) ‘complicated cases’ include antepartum or postpartum haemorrhage, prolonged or obstructed labour, postpartum sepsis, complications of abortion, pre-eclampsia/eclampsia, ectopic pregnancy, and ruptured uterus. Anaemia, malaria, tuberculosis, and other pre-existing conditions that may complicate delivery are considered indirect obstetric complications. Rarely are the definitions for these terms for obstetric complications—direct or indirect—more specified.”¹¹
5. Although the exact prevalence of maternal morbidity is not known, recent research estimates that global severe maternal morbidity rates are increasing¹² and that “substandard maternal health care and suboptimal use of evidence-based strategies to prevent and treat morbidity are common across many countries regardless of wealth, contributing to the high burden of severe maternal morbidity.”¹³

Health Systems and Maternal Morbidities

6. The Office of the United Nations High Commissioner for Human Rights (OHCHR) stressed that “[h]ealth systems are more than delivery apparatus for interventions and commodities. A society in which rich and poor women alike – irrespective of race, ethnicity, caste, disability or other characteristics – can rely on the health system to

⁸ Tabassum Firoz, Doris Chou, Peter von Dadelszen, Priya Agrawal, Rachel Vanderkruik, Ozge Tunçalp, Laura A Magee, Nynke van Den Broek, Lale Say & for the Maternal Morbidity Working Group, Measuring maternal health: focus on maternal morbidity, World Health Organisation available at <https://www.who.int/bulletin/volumes/91/10/13-117564/en/>

⁹ Marge Koblinsky, Mahbub Elahi Chowdhury, Allisyn Moran, and Carine Ronsmans; Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health; J HEALTH POPUL NUTR 2012 Jun;30(2):124-130; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3397324/pdf/jhpn0030-0124.pdf>

¹⁰ United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

¹¹ Marge Koblinsky, Mahbub Elahi Chowdhury, Allisyn Moran, and Carine Ronsmans; Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health; J HEALTH POPUL NUTR 2012 Jun;30(2):124-130; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3397324/pdf/jhpn0030-0124.pdf>

¹² Geller SE, Koch AR, Garland CE, et al. A global view of severe maternal morbidity: moving beyond maternal mortality. Reproductive Health. 2018 Jun;15(Suppl 1):98. DOI: 10.1186/s12978-018-0527-2, pages 31, 41.

¹³ Geller SE, Koch AR, Garland CE, et al. A global view of severe maternal morbidity: moving beyond maternal mortality. Reproductive Health. 2018 Jun;15(Suppl 1):98. DOI: 10.1186/s12978-018-0527-2, page 39.

meet their sexual and reproductive health needs fairly is a more just society”¹⁴ and that “[w]hile the prevention of maternal mortality and morbidity often depends on the provision of relatively economical and simple interventions, deaths cannot be fully prevented without an overall functioning health system and a stable infrastructure for transportation of implements and patients, as well as a system for education, the provision of information, and accountability.”¹⁵ The organisation, design, financing of health systems world over is illustrative of the lack of priority and/or attention placed on women’s health and rights.¹⁶

7. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has highlighted;
 - “the global trend towards privatization in health systems poses significant risks to the equitable availability and accessibility of health facilities, goods and services, especially for the poor and other vulnerable or marginalized groups. In many cases, privatization has led to increased out-of-pocket payments for health goods and services, disproportionate investment in secondary and tertiary care sectors at the expense of primary health care, and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas.”¹⁷

8. This privatisation is fuelled and exacerbated by persistent deficits, unavailability of public funds in absolute terms and low prioritisation of health by governments in their public expenditure. None of these factors work alone and regularly they feed into each other resulting in making health systems inaccessible for the ones that most need it. Further, for women and girls, these structures and governance failures do not operate singly; they combine with and compound systemic and institutional discriminations in every society. The impact of privatisation means that profit is prioritised over rights of patients and everyone is viewed as customers, consequently the ones that are prioritised are the ones with higher buying/bargaining power. This automatically means that marginalised groups who have lesser buying power do not have access to health services resulting in further marginalisation. They are often turned away or accrue crippling debts to access basic health care because privatisation is always accompanied by erosion of social services increasing morbidity. This, compounded with discrimination based on gender, race, caste, class, sexuality and gender non-conformity among other grounds, and the criminalisation and environment of fear created by state and non-state actors regularly results in the violation of many women’s and girls’ basic right to life

¹⁴ Office of the High Commissioner of Human Rights, *Technical Guidance on the application of human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity*. Report of the Office of the High Commissioner of Human Rights, July 2012, [A/HRC/21/22](#), last accessed on 12 July 2018, at 2.33 pm.

¹⁵ United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, para 43 <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

¹⁶ Office of the High Commissioner of Human Rights, *Technical Guidance on the application of human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity*. Report of the Office of the High Commissioner of Human Rights, July 2012, [A/HRC/21/22](#), paras 44 - 53

¹⁷ A/HRC/67/302, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on health financing in the context of right to health available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N12/461/01/PDF/N1246101.pdf?OpenElement>

before, during and post pregnancy. There are many manifestations of these multiple factors and each represents the state's failure to prioritise and address the systemic failures in the health systems putting women and girls' lives and well-being at risk. The Special Rapporteur on Violence against Women, Its Causes and Consequences in her report to the General Assembly highlights that, "the poor working conditions of many health professionals and the historical overrepresentation of men in the gynaecological and obstetrical field is in contrast with the obligation of States to ensure the availability and quality of maternal health-care facilities, goods and services, the adequate training of providers and the gender balance of the health professionals"¹⁸

9. International cooperation is one of the human rights principles agreed to by states¹⁹ and human rights bodies²⁰ necessary to address maternal mortality and morbidity. However, international funding and technical cooperation practices are often harmful to existing health systems and undermine human rights. Generally, "funders fail to focus their activities on the health needs of recipient states and direct assistance towards health systems development, inadequately incorporate the inputs of affected communities in their activities, and attach conditionalities to the receipt of funding for health."²¹ International health financing is not designed to make existing domestic health systems sustainable. On the contrary, it has the impact of making health financing reliant only on international financing. Consequently, every change in donor priority requires a complete overhaul of health infrastructure in the recipient country. One of the most prominent examples illustrating this phenomenon is the reinstatement of the Mexico City Policy also known as the Global Gag Rule by the United States of America.²² This results in an absence of sustained well-developed, context-specific, available, accessible, acceptable and quality institutions or commodities for people. In the case of women's and girls' health this is linked to the ways in which health systems are not adequately equipped to deal with health complications linked to pregnancy, and to the fact that women and girls' autonomy is not the basis for health options. Traditional systems in global south states are upended to "modernise" without adapting to the context of these states. Some examples include the kinds of contraception available and pushed into global south economies, and the dismantling of traditional birth attendant systems instead of training or adapting the existing systems, among others.

¹⁸ A/74/137; Special Rapporteur on Violence against Women, Its Causes and Consequences in her report to the General Assembly on a human rights-based approach to mistreatment and violence in reproductive health services with a focus on childbirth and obstetric violence, para 39; available at https://www.un.org/en/ga/search/view_doc.asp?symbol=A/74/137,

¹⁹ Refer to A/HRC/RES/39/1, Preventable maternal mortality and morbidity and human rights in humanitarian setting, available at https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/RES/39/10

²⁰ Refer to CESCR General Comment 14,

²¹ A/HRC/67/302, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on health financing in the context of right to health available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N12/461/01/PDF/N1246101.pdf?OpenElement>

²² To understand the impact of the same please refer to <https://www.ippf.org/global-gag-rule>, <https://www.hrw.org/news/2018/02/14/trumps-mexico-city-policy-or-global-gag-rule>

Intersectionality

10. As highlighted by an Expert Group Meeting on gender and racial discrimination convened by the OHCHR in 2000, “[t]he idea of ‘intersectionality’ seeks to capture both the structural and dynamic consequences of the interaction between two or more forms of discrimination or systems of subordination. It specifically addresses the manner in which racism, patriarchy, economic disadvantages and other discriminatory systems contribute to create layers of inequality that structures the relative positions of women and men, races and other groups. Moreover, it addresses the way that specific acts and policies create burdens that flow along these intersecting axes contributing actively to create a dynamic of disempowerment.”²³ OHCHR has tied this type of multiple and compounded discrimination to “a heightened inability to access adequate health-care systems and timely interventions and services, although the reasons for this inability may differ. For example, laws or social practices often place age limits, or restrictions related to marital status, on access to sexual and reproductive health care, services and information. Meanwhile for reasons of distance, cost and lack of information women living in rural areas, indigenous women, displaced persons/refugees, girls, or women of lower social and economic status may not have sufficient access to antenatal services, emergency obstetric care and skilled birth attendants.”²⁴
11. Addressing maternal morbidities needs to take into account that “women’s reproductive pathways are as much social as they are biological and include practices that can place them at a disadvantage.”²⁵ And maternal morbidities is one such manifestation of the social and economic disadvantage the systems and structures place women and girls. The very nature of morbidities and lack of sustained data collection of the incidence of morbidities are indicative of the low priority afforded to this issue. It has been reported that there are “gaps in the quality of methods and reporting used in systematic reviews on maternal conditions. Crucially, for 56% of the direct and 30% of the indirect estimates, there was insufficient information to verify the population or data source. Overall, 34% of the estimates extracted included facility-based studies.”²⁶ However, this information is from self-reporting from women and more reliable population-based estimates are needed, since women who access facilities are often different to the ones who do not.²⁷
12. Institutional, structural and societal discrimination based on gender further impacts women and girls’ life before, during and post pregnancy. For example, anaemia resulting from inadequate nutrition and food insecurity has severe implications on women and girls’ health and well-being pre- and post-pregnancy. It further impacts on

²³ UN Division for the Advancement of Women, Office of the High Commissioner for Human Rights, and the United Nations Development Fund for Women. *Report of the Expert Group Meeting on Gender and Racial Discrimination*. 21-24 November 2000, available at <http://www.un.org/womenwatch/daw/csw/genrac/report.htm>

²⁴ United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, para 20 <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

²⁵ <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0214199&type=printable>

²⁶ Giorgia Gon, Andreia Leite, Clara Clavert, Susanah Woodd, Wendy J Graham, Veronique Filippi, The frequency of maternal morbidity: A systematic review of systematic reviews:

²⁷ Giorgia Gon, Andreia Leite, Clara Clavert, Susanah Woodd, Wendy J Graham, Veronique Filippi, The frequency of maternal morbidity: A systematic review of systematic reviews:

recovery arising from any complication and the resulting long-term complications on women and girls' bodies. "Anaemia does not just stand at the intersection of health and nutrition; it also stands at the intersection of culture and gender."²⁸ The Committee on Economic, Social and Cultural Rights has also reaffirmed the same in its General Comment 22:

"[T]he right to sexual and reproductive health is also deeply affected by "social determinants of health", as defined by WHO. In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distribution of power based on gender, ethnic origin, age, disability and other factors. Poverty, income inequality, systemic discrimination and marginalization based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well. The nature of these social determinants, which are often expressed in laws and policies, limits the choices that individuals can exercise with respect to their sexual and reproductive health. Therefore, to realize the right to sexual and reproductive health, States parties must address the social determinants as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health."²⁹

13. The systemic oppressions mentioned above operate differently upon the bodies of women and girls who are historically discriminated against including racial and ethnic minorities, indigenous women, women with disabilities, young women, adolescent girls, women living HIV among others. Some illustrative examples of the same are given below. Some commonalities in all these case studies are that they indicate the exacerbated and compounded barriers faced by women who have to overcome not only the inadequate and grossly sufficient health system but also the systemic oppressions of the society which the health system replicates.
14. Discrimination faced by women living with HIV remains a pervasive problem that exists world over. The stigma and discrimination has a negative impact at various levels. However, scarcity of information or data around particular morbidities faced by women means that these concerns are not listened to, stories of women being turned away or forced to give birth in hospital toilets, or being put last in the queue after 'more deserving' i.e. HIV negative women are given care first (irrespective of their stage of labour) are commonplace. HIV positive women routinely describe the violence and discrimination they are subjected to by healthcare providers. For instance, in a study in Tamil Nadu, a state in India, highlighted "that [the] majority of the HIV-infected mothers have been victims of ill behaviour from the health staff". In another such study, as many as 97% of such women reported stigmatization while 50% expressed that they would

²⁸ Lange L, Gherissi A, Chou D, Say L, Filippi V (2019) 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 14(4): e0214199. <https://doi.org/10.1371/journal.pone.0214199>

²⁹ UN Committee on Economic, Social and Cultural Rights (CESCR), General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, [E/C.12/GC/22](https://www.unhcr.org/refugees/article/12/GC/22), para. 8

never like to avail of maternity care at a government hospital. Stigmatization included avoidance of physical examinations, derogatory comments, unnecessary referrals, and even refusal to provide intra-partum care. Similarly, HIV-positive women in rural North Karnataka have consistently expressed that discrimination and negative attitude of the staff forms an important barrier for access to health care in the medical facility.”³⁰ Stigma and discrimination by health care providers is also one of the factors for discontinuation of ART post giving birth. Further, unnecessary referrals during the intra-natal period, which makes delivery of PPTCT services a challenging issue.

15. Sexist, racist, ableist, and colonialist sterilization practices in Canada have disproportionately impacted Indigenous women.³¹ For Indigenous women, involuntary sterilization has been practiced through legislative frameworks and informal practices which targeted and/or failed to protect Indigenous women. While the literature on this topic tends to treat women with disabilities and Indigenous women separately, it is important to recognize that legal mechanisms to sterilize women with disabilities were targeted at Indigenous women through ableist, racist and classist assumptions on their abilities and capacity.³² Indigenous women in the Americas, particularly from Canada, Bolivia and Perú, have turned to the Inter-American System of Human Rights³³ to denounce how they are forced to abort, or have their children removed if they carry their pregnancy to term, and subsequently forcibly sterilized, sometimes at the behest of social services who weaponize the custody of their children.³⁴

16. Women with disabilities not only face several barriers in accessing health and social protections systems and services, they will also see their own maternity challenged in ways non-disabled women might not. How women with disabilities access health systems and services, social security systems and community services is a factor to consider into assessing the prevalence of maternal morbidities as well as its consequences. Lack of access to health and social determinants of health very likely impact the prevalence of maternal morbidities on women with disabilities. Maternal morbidities may also lead to women acquiring disabilities. Women with disabilities “are significantly overrepresented in child protection proceedings and disproportionately lose contact and custody of their children, who are subject to adoption proceedings and/or to being placed in an institution. In addition, a husband can be granted

³⁰ Anita Nath; Paediatric HIV in India: Current scenario and the way forward; Indian Journal of Public Health, 2017, Volume 21, Issue 2, pg 124 -130, available at, <http://www.ijph.in/article.asp?issn=0019-557X;year=2017;volume=61;issue=2;spage=124;epage=130;aulast=Nath>

³¹ Karen Stote, (2012). The coercive sterilization of aboriginal women in Canada. American Indian Culture and Research Journal, 36(3), 117-150.

³² Natalia Acevedo, The medical discourse and the sterilization of people with disabilities in the United States, Canada and Colombia: From eugenics to the present, (2015), P. 99-101

³³ See, e.g. Inter-American Court of Human Rights, I.V. v. Bolivia, Preliminary objections, merits, reparations and costs, 30 November 2016; EFE, Víctimas de esterilizaciones forzadas pedirán a la CIDH que juzgue a Fujimori, 11 January 2018, available at: <https://www.efe.com/efe/cono-sur/sociedad/victimas-de-esterilizaciones-forzadas-pediran-a-la-cidh-que-juzgue-fujimori/50000760-3489734> ; Forum of the Inter-American Human Rights System, Forced Sterilizations of Indigenous Women in the Americas, November 2019, agenda available at: <https://www.oas.org/es/cidh/docs/pdfs/2019/ForoInteramericano-AgendaAmpliada-en.pdf>

³⁴ Some of this information has been provided by Alisa R. Lombard, B. S.Sc., LL.L., JD, attorney at Semaganis, Worme, Lombard, law firm proposing several class actions in Canada representing over 55 Indigenous women in Canada.

separation or divorce on the basis of his wife's psychosocial disability."³⁵ Hence, maternal morbidities could likely lead to further questioning of the ability to mother that women in general already face. However, initiatives to address maternal morbidities must do so in a way it does not stigmatize women with disabilities, including women with psychosocial and intellectual disabilities, by framing their lives and motherhood as undesirable, burdensome or unworthy of living.

Maternal Mental Health

17. The right to health includes the right to the highest attainable standard of mental health. Pregnancy has a profound impact on women's and girls' mental health for medical and non-medical reasons. Worldwide about 10% of pregnant women and 13% of women who have just given birth experience mental ill health, primarily depression. These statistics are even higher in low income countries, i.e. 15.6% during pregnancy and 19.8% after child birth³⁶. Post-partum depression is recognized as major global health challenge, is a form of maternal morbidity that causes enormous suffering and in severe cases can lead to suicide.

18. While all pregnant women can be at risk for mental ill health, it is telling that risk factors include mostly socially determined elements such as poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, and low social support generally³⁷. The Special Rapporteur on Health has noted that the burden of managing and coping with systemic damage has fallen on individuals and results in inadequate attention to structural root causes of ill health and a corresponding lack of State accountability for its obligations to respect, protect and fulfil all individuals right to health, including mental health³⁸. This is particularly true for maternal mental health whereby women and girls are confronted with gender injustice in almost all facets of their lives because of their perceived reproductive capacity and then, paradoxically, pregnancy often compounds the multiple and intersecting forms of injustice experienced. Such injustice can lead to death, disability and poor physical and mental health, all of which are preventable, because of the State's failure to prioritize a human rights based approach to maternal health that respects women's and girls' sexual and reproductive rights.

Unsafe Abortion

19. Unsafe abortion is one of the leading causes of maternal mortality,³⁹ consequently an assumption could be made about impacts on the surviving women's health. However, this remains an assumption due to scarcity of data. Further, when abortion services are restricted and stigmatised across the world, women are not liable to come forward with information regarding the abortion or possible impact. Research on abortion-related morbidity in settings with limited access to abortion services has highlighted that

³⁵ UN Committee on the Rights of Persons with Disabilities (CRPD), General Comment No. 3 (2016) on women and girls with disabilities, 25 November 2016, CRPD/C/GC/3, para. 46

³⁶ See WHO https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

³⁷ Ibid

³⁸ A/HRC/41/34

³⁹ See World Health Organisation, <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

“defining and accurately measuring abortion-related morbidity is important for understanding the spectrum of risk associated with unsafe abortion and for assessing the impact of changes in abortion-related policy and practices.”⁴⁰ And yet, statistics on maternal morbidity due to unsafe abortion are rare and often rely on estimates that are not without limitations.⁴¹ Singh and Maddow-Zimet estimated that in 2012, 7 million of women in the Global South were treated for complications arising from unsafe termination of pregnancy after reaching health facilities, based on data from 26 countries.⁴²

20. Available evidence does find that the prevalence of least-safe abortions increases with increased restrictions on access to safe abortions and that the proportion of least-safe abortions increases from 1% in high-income countries to 5% in upper-middle-income countries, 20% in lower-middle-income countries and 54% in low-income countries⁴³. This places a higher burden on health systems in countries that can least afford it and for entirely non-medical related reasons.
21. States have an obligation, even in restricted legal settings, to ensure access to post abortion care. This has been recognized through the treaty bodies as well as intergovernmental negotiated agreements including the ICPD Programme of Action and the Beijing Platform for Action. However, in countries with severe restrictions on abortion, many women who experience complications from unsafe abortion put off seeking care until their symptoms become life threatening.⁴⁴ This is starkly illustrated in countries such as El Salvador where women are incarcerated for seeking out abortion services resulting in a chilling effect for women and health providers⁴⁵.
22. Removing legal and other restrictions to safe abortion and expanding access to this critical health service is at the heart of a human rights based approach to preventable maternal morbidity, precisely because it addresses the social, cultural and legal conditions that contribute to **preventable** violations of women’s and girls sexual and reproductive rights.

⁴⁰ Calvert C, Owolabi OO, Yeung F, et al. The magnitude and severity of abortion-related morbidity in settings with limited access to abortion services: a systematic review and meta-regression. *BMJ Glob Health* 2018;3:e000692. doi:10.1136/bmjgh-2017-000692, page 1.

⁴¹ See e.g. the WHO’s estimate in its evidence brief on preventing unsafe abortion, which states that “[u]nsafe abortions lead to an estimated 7 million complications” (<https://apps.who.int/iris/bitstream/handle/10665/329887/WHO-RHR-19.21-eng.pdf?ua=1>), based on estimates which its authors acknowledge have several significant limitations. (Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG* 2016;123: page 1494).

⁴² Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG* 2016;123:1489–1498.

⁴³ Ganatra B et al., Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, *Lancet*, 2017, published online Sept. 27. [http://dx.doi.org/10.1016/S0140-6736\(17\)31794-4](http://dx.doi.org/10.1016/S0140-6736(17)31794-4).

⁴⁴ Singh S., Remez, L., Sedgh, G., Kwok, L., and Onda, T. *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. Guttmacher Institute, 2018.

⁴⁵ CEDAW/C/SLV/CO/8-9 para 36-37.

Recommendations

- Ensure access to available, accessible, acceptable and quality sexual and reproductive health services as part of universal health coverage and public health systems, including modern contraceptive options, comprehensive abortion and post-abortion care, financed adequately through taxation and free from control from other governments, and transnational corporations.
- Women and girls should be consulted during the design, implementation, monitoring and evaluation of SRHR programmes and policies and ensuring their meaningful participation.
- Remove all legal and social barriers to safe abortion, including its criminalization, which is broader and including sanctions and no sanction regimes, and commit to providing safe abortion services on request including removal of third party authorisation requirements for all SRHR, pre, during and post pregnancy services.
- Address social and other determinants of health in law and practice from an intersectional perspective to ensure that they enable all individuals to effectively enjoy their sexual and reproductive rights.
- Hold private companies, insurance providers, health providers, and multinational corporations accountable for unethical research practices, violations and abuses of women and girls' reproductive rights and bodily autonomy.
- Prioritise data collection on different forms of maternal morbidities, including mental ill health, and their causes in order to effectively address maternal morbidities.