UNFPA submission: follow-up report on the application of a human rights-based approach (HRBA) to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity

Ending preventable maternal mortality and morbidity remains fundamental to achieving global development goals. All women, everywhere, need to receive high-quality care before and during pregnancy, labor, childbirth, and the postpartum period. The current reality falls short of this, and the risk of death remains tragically high[1]. As countries reduce maternal mortality and improve health systems, maternal morbidity tends to increase[2]. Relying solely on maternal mortality to assess a country's status in the area of maternal health overlooks the importance of maternal morbidity, which is not only a precursor to maternal mortality but also a potential cause of lifetime disability and poor quality of life[3]. This is central to the spirit of the Sustainable Development Goals (SDGs), which aspire to look beyond survival to health, empowerment, and well-being.[4]

The 2019 ICPD25 Nairobi Summit, organized by UNFPA and the Governments of Kenya and Denmark, acknowledged that the most vulnerable and poorest people with the least access to health care -including women and girls, bear a disproportionate burden of poor sexual and reproductive health outcomes. Consequently, a comprehensive approach to sexual and reproductive health rights (SRHR) is needed to address gaps in the delivery of interventions as well as the legal, political, social, cultural, gender, ethnic, and economic barriers that prevent people from fully achieving their SRHR[5].

Poor sexual and reproductive health remains a leading cause of disability and death for women of childbearing age worldwide[6]. Such disability includes morbidities from obstetric-related complications such as prolonged, obstructed labor leading to obstetric fistula, stillbirth, iatrogenic fistula, complications of unsafe abortion, obstetric hemorrhage, hypertensive disease, anemia, postpartum depression, incontinence, pelvic organ prolapse, HIV/AIDS and other STIs, malaria, TB, pelvic inflammatory disease, etc.[7]. The Global Strategy for Women's, Children's and

[1] Maternal morbidity: Time for reflection, recognition, and action Lale Say, Doris Chou, and the WHO Maternal Morbidity Working Group (MMWG)

[2] Souza JP, Tuncalp O, Vogel JP, *et al*. Obstetric transition: the pathway towards ending preventable maternal deaths. *BJOG* 2014;121:1–4.

[3] Measuring maternal health: focus on maternal morbidity- Bulletin of the World Health Organization 2013;91:794-796. doi: http://dx.doi.org/10.2471/BLT.13.117564 (accessed October 2019)

[4] Maternal morbidity: Time for reflection, recognition, and action. Lale Say Doris Chou on behalf of the WHO Maternal Morbidity Working Group (MMWG), First published: 23 May 2018 https://doi.org/10.1002/ijgo.12499

[5] Sexual And Reproductive Health And Rights: An Essential Element Of Universal Health Coverage - Background document (2019) - https://www.unfpa.org/featured-publication/sexual-and-reproductive-health-and-rights-essential-element-universal-health

[6] UN report on obstetric fistula 2018. http://www.endfistula.org/publications/un-report-obstetric-fistula-2018

[7] https://www.ncbi.nlm.nih.gov/books/NBK361917/

Adolescents' Health (2016–2030): Survive, Thrive, Transform[8] and other initiatives[9] emphasize a reduction in maternal, newborn, child mortality as well as a holistic approach to improving the health and wellbeing of women, children and adolescents. UNFPA's Maternal and Newborn Health Thematic Fund (MHTF) has since 2008 supported 39 countries in ensuring a just, effective and efficient health system where every woman, adolescent girl and newborn has equitable access to quality maternal and newborn health-care through a people-centered approach. The MHTF promotes quality, accessible and midwifery care, emergency obstetric and neonatal care (EmONC), prevention and treatment of obstetric fistula, and maternal and perinatal death surveillance and response (MPDSR). It also addresses other reproductive health issues such as cervical cancer, safe abortion (where legal) and post-abortion care.

In replying to this call for submissions, UNFPA has collected inputs from its country offices in Asia and the Pacific and East and Southern Africa on our actions in support of a human rights-based approach to preventing maternal mortality and morbidity, as well as various initiatives under the Campaign to End Fistula. The first part of this submission presents key trends from country experiences (full responses in the annex), while the second focuses on obstetric fistula as a preventable maternal morbidity.

[8] Every Woman Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Survive, Thrive, Transform. 2015. http://www.who.int/life-course/partners/global-strategy/ewecglobalstrategyreport-200915.pdf Accessed January 2020

[9] Ending Preventable Maternal Mortality; Every Newborn Action Plan; the H6; the Spotlight Initiative; Quality, Equality & Dignity network; White Ribbon Alliance[9]; the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation; the UNFPA-UNICEF Global Programme to End Child Marriage; the UNFPA-led Campaign to End Fistula, etc.)

A. Key trends from UNFPA programming countries

1. **What steps has your Government or organization taken to utilize a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity, including in the context of humanitarian settings? How has the technical guidance assisted your Government or organization in designing, implementing, revising and/or evaluating such policies and programmes?**

Several countries have taken steps to ensure a HRBA in eliminating maternal mortality and morbidity, namely by ensuring greater **affordability** of services. India, for instance, has put in place different safety net programmes to ensure the poorest women have access to antenatal and neonatal care while Sri Lanka has provided free and near-universal registration and follow-up visits of pregnant women as early as the first trimester. Solomon Islands, likewise, has a free public healthcare scheme that includes maternal care.

Furthermore, UNFPA in Burundi has increased the **availability** of emergency obstetric and newborn care services (EmONC) by providing equipment and training at health facilities, while Zambia has launched community-based distributors of sexual and reproductive health commodities for rural women. UNFPA in Namibia further built the capacity of EmONC providers on quality of care.

In Uganda and Zambia, UNFPA has respectively focused on supporting **accountability** through rolling out the technical guidance (with the national human rights institution and the Ministry of Health), monitoring violations of SRHR, and supporting the systematic process of conducting maternal and perinatal death reviews.

Finally, UNFPA in Bangladesh has noted good practices in promoting **equality and nondiscrimination** through focusing on those most at risk of maternal mortality with sexual and reproductive health information and commodities (e.g. refugee women and teagarden workers). Indonesia, on the other hand, has assessed the underlying causes of maternal mortality, including discriminatory laws and socio-cultural barriers (.e.g. marriage laws and opposition to abortion).

2. **What challenges does your Government or organization face in implementing a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? Please elaborate on the nature of these challenges and steps taken to address them.**

Many countries have reported **legal and socio-cultural barriers** for sexual and reproductive health rights and women's bodily autonomy generally, and for ending child marriage and accessing safe abortion more specifically. In Bangladesh and Solomon Islands for instance, the legislation that permits child marriage gives rise to risky adolescent pregnancies, and in Indonesia and Sri Lanka, restrictive laws on abortion contribute to unsafe abortions. In parallel, conservative discourses along religious and moral lines, have curtailed access to sexual and reproductive

healthcare and information for adolescents, unmarried couples and women in Indonesia, Zambia and Sri Lanka.

Additionally, various countries stressed **human resources gaps** as well as **gaps in skills** to provide human rights-based maternal care. For instance, in Bangladesh, Burundi and Ethiopia, frequent changes in personnel due to mobility create a training burden, and in Solomon Islands, Sri Lanka and Namibia, health personnel lacked skills to implement a HRBA to maternal care. More gravely, maternal death reviews in Namibia showed that health worker-related factors were a leading cause of maternal mortality with major challenges around the skills and attitudes of health workers. Broadly, countries noted that maternal death reporting was weak due to a lack of data and institutionalization of the process (India, Solomon Islands).

Many other **structural challenges** were noted by countries ranging from poor accountability at facility and health system levels (Sri Lanka), pervasiveness of un-recommended medical practices such as episiotomies (Bangladesh, India) as well as limited resources and lower profile for SRHR in the elaboration of budget and policies (Burundi, Uganda, Zambia). In Uganda and India, there was both a shortage of specialized medical personnel and a concentration of available personnel in urban areas, ensuing in poor coverage of rural populations.

3. **Please provide information on the main areas of concern specifically in relation to maternal morbidities in your country and/or context. Please elaborate on the main causes leading to maternal morbidities in your country and/or context?**

While some countries flagged grave **delays in care** for obstetric emergencies (Bangladesh, Burundi, Zambia), others reported an increasing burden of **HIV and other non-communicable diseases** contributing to maternal morbidities (Solomon Islands, Sri Lanka, Uganda, Zambia). Moreover, due to home births and delays in care, prolonged obstructed labor often resulted in **a high burden of obstetric fistula** in Bangladesh, Uganda and Zambia, while **postpartum depression** appeared to be on the rise (India). MPDSR and monitoring of morbidities were not systematic in several countries, causing a **lack of data on maternal mortality and morbidity** (Indonesia, India, Solomon Islands). Most countries reported **postpartum/obstetric hemorrhage** and **hypertensive disorders** leading causes of maternal mortality and had limited data on morbidities (Bangladesh, Indonesia, Namibia, Sri Lanka, Uganda, Zambia). They also noted the **scarcity of blood banks** and **low geographical coverage** of rural and hard to reach areas by EmONC facilities. These inequities were flagrant in India where they translated in very stark differences in prevalence of facility-based deliveries and maternal mortality among rural and urban women, and wealthiest and poorest women.

4. **Is there particular group of women and girls who are more at risk of maternal morbidities? (For instance, adolescents, women living with HIV, indigenous women, women of African descent, women from rural areas etc.)**

The inputs shared by UNFPA country offices suggest that maternal morbidities are influenced by **multiple intersecting factors such as age, ethnicity, geographic location, economic status,**

HIV status, migration status, etc. While adolescent girls were relatively at higher risk of maternal morbidity in all countries, multiple countries also mentioned the dire situation facing poor women -including in urban settings- and rural women (Afghanistan, Ethiopia, Bangladesh, Burundi, India,, Somilia Zambia). Obstetric fistula, for instance, primarily affects poor rural women and adolescent mothers living in remote areas where the health services are scarce and limit access to professional maternal health-care services. Women from ethnic minorities and indigenous women (Bangladesh, Burundi, India,) and women living with HIV and migrant women (Ethiopia, Namibia, Uganda, Zambia) are also at particular risk of maternal morbidities.

5. **What type of measures are in place to prevent maternal morbidity, including laws, policies and programmes? How has a human rights-based approach informed such measures?**

Countries have reported **measures to prevent maternal mortality -and to a lesser maternal morbidities, with varying levels of specificity and comprehensiveness**. Preventing and eliminating maternal morbidities including fistula is at the heart of UNFPA's mandate and it is embedded in the Strategic Plan 2018-2021. The Fistula campaign consists of a four-pillar strategy: prevention, treatment, social reintegration, and advocacy. In Ethiopia and Sri Lanka, a general right to health that includes maternal health is constitutionally protected. While in Uganda, the right to health is only implied in the Constitution and the Ministry of Health has been responsible for championing several laws and policies on maternal health. Indonesia declared a similar pattern with a national law on health and several decrees by the Ministry of Health on maternal mortality and morbidities. India, likewise, has a national health policy –which includes maternal health- and has taken steps to expand the coverage and effectiveness of its Medical Termination of Pregnancy Act. With the support of UNFPA, countries such as Bangladesh, Namibia, Solomon Islands and Zambia have dedicated laws and policies to maternal health doubled with guidelines and programming efforts to reduce maternal morbidities. It appears from this that **few countries have adopted a comprehensive package** going from legislation, to targeted policies and programmes to support the implementation of laws on maternal morbidities.

6. **What measures are in place to support women and girls affected by maternal morbidities, including targeted programmes aiming at addressing their specific needs?**

Countries such as India and Sri Lanka have multiple government-led initiatives for free neonatal and maternal care. On the other hand, in Uganda, civil society has used strategic litigation to redress maternal deaths, hence strengthening accountability of the State for maternal health. In Bangladesh, UNFPA has focused on procuring **reproductive health commodities** to newlyweds and garment factory workers. In Uganda, UNFPA has provided child brides and teenage mothers with **life skills training** and support for re-enrollment at school. Moreover, UNFPA with WHO have provided adolescent sexual and reproductive **health counselling and CSE** to prevent unintended pregnancies in Namibia, and empowered adolescent girls with life skills and **GBV mitigation strategies** in Bangladesh. At a broader level, UNFPA supports the scale-up of national capacities to prevent and treat obstetric fistula, and to provide social reintegration services. In

doing this, UNFPA has supported free obstetric care and fistula repair surgeries and referrals for underprivileged girls and women in more than 39 countries. UNFPA has also promoted the rehabilitation and social reintegration of fistula patients through life skills training, small-scale funding and connection with livelihoods opportunities at community-level.

7. **Does your Government or organization regularly collect and analyze disaggregated data and information on maternal morbidities? Please elaborate on good practices and challenges in this regard.**

UNFPA's Maternal Health Thematic Fund supports countries in strengthening the monitoring of maternal and newborn health through routine data collection and analysis. It also helps bolster the use of sexual and reproductive health data, particularly at facility and district levels to stimulate locally-driven efforts to improve the availability and quality of care. While primarily focusing on routine data collection and health management information systems, the MHTF also assists with surveys to complement routine data if needed, such as EmONC needs assessments, midwifery workforce assessments, and surveys on obstetric fistula prevalence and incidence.

However, very **few countries reported an institutionalized and nation-wide process for reporting and reviewing maternal deaths and morbidities**. **Multiple countries reported collecting data only on maternal mortality while experiencing capacity issues in monitoring maternal morbidities**, especially at larger scale (India, Indonesia, Solomon Islands). From the 39 countries supported by UNFPA's Maternal Health Thematic Fund, a half (14) had a nation-wide process for reporting and reviewing maternal and perinatal deaths in 2019. When countries collected data on morbidities through the district health information system, home births were not being recorded. Zambia, Uganda and Sri Lanka had fairly institutionalized processes for maternal and perinatal death surveillance and response (MPDSR), including analysis on maternal morbidities in the case of Sri Lanka and Zambia. However, Sri Lanka noted that health workers were not well sensitized regarding the process for MPDSR and Uganda stressed that yearly MPDSR reviews were rarely complete.

B. Focus on the Campaign to End Fistula

On 17 December 2018, the Human Rights Council adopted resolution 73/147 on preventable maternal mortality and morbidity and human rights, in which it reaffirmed a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity and supported the intensification of efforts to end obstetric fistula. The resolution follows previous Human Rights Council resolutions related to the issue, including resolutions 62/138 of 18 December 2007, 63/158 of 18 December 2008, 65/188 of 21 December 2010 and 67/147 of 20 December 2012 on supporting efforts to end obstetric fistula and its resolutions 69/148 of 18 December 2014 and 71/169 of 19 December 2016 on the intensification of efforts to end obstetric fistula.

A key contributor to promoting the rights, dignity, and well-being of women and girls, as enshrined in the Programme of Action of the International Conference on Population and Development (ICPD) and related Sustainable Development Goals is the UNFPA-led flagship Campaign to End Fistula. Aimed at "leaving no one behind" and "reaching the furthest behind first," the global Campaign contributes to achieving SDGs 1, 3, 4, 5, 10, and 17. The Campaign to End Fistula brings together nearly 100 partners at global, national and subnational levels and is active in over 55 countries across Africa, Asia, the Arab States and Latin America. As noted in the UN Secertary General's Report on ending obstetric fistula (2018)[10], the persistence of obstetric fistula, one of the most severe maternal morbidities, is driven by poverty, gender and socio-economic inequality, lack of education, child marriage and early/adolescent childbearing. The occurrence of the condition indicates a violation of the rights of affected women and girls and a failure of health systems. In 2018, UN Member States adopted a resolution[11], calling for increased investment and accelerated action to end obstetric fistula by 2030. The UNFPA–led global Campaign to End Fistula[12], launched in 2003, is a key force behind ending the health and human rights tragedy of obstetric fistula. UNFPA focuses on (i) building the capacity of duty bearers in the development and public health realm; (ii) supporting the design and implementation of national strategies and policies, (iii) investing in strengthening health systems, (iv) ensuring adequately trained and skilled human resources, and (v) providing support for the development and maintenance of services and infrastructure to provide access to comprehensive emergency obstetric care, and address underlying medical, socioeconomic, cultural and human rights determinants. By the end of 2018, UNFPA and the Campaign had assisted twenty–one fistula-burdened countries[13] to develop national strategies to prevent fistula, ensure availability of quality fistula treatment and help reintegrate affected women and girls back into society. Thirty government-led fistula task teams were also strengthened to enhance coordination, implementation and monitoring of interventions to eliminate fistula. By 2018, over 105,000 fistula repair surgeries were directly supported by UNFPA, to help restore hope, healing and health to women and girls with fistula.

[10] http://www.endfistula.org/publications/un-report-obstetric-fistula-2018
[11] http://www.endfistula.org/publications/un-resolution-fistula-2018
[12] http://www.endfistula.org/campaign- The Campaign to End Fistula
[13] Benin, Nigeria, Ghana, Uganda, Burkina Faso, Congo, Cote d'Ivoire, Democratic republic of Congo, Ethiopia, Guinea Conakry, Guinea Bissau, Madagascar, Mali, Mozambique, Niger, Senegal, South Sudan, Togo, Yemen, Afghanistan, Cameroon

Key challenges

- Though some progress is reported in addressing obstetric fistula, urgent and significantly increased actions and investments are required to eradicate this morbidity by 2030. Stronger, high level political, financial, and action-oriented leadership and commitments at all levels is critical, and a key driver of progress towards ending fistula.
- Persistence of root causes, including poverty, gender inequality, and sociocultural barriers, continue to hinder efforts to end fistula. An increased focus on social determinants that affect the well-being, empowerment and rights of women and girls, is needed.
- Inadequate health-care systems – Strong health systems are required to effectively address quality of care to prevent maternal morbidities. In Afghanistan, Bangladesh, Guinea, Guinea-Bissau, Kenya, Somalia, and Zambia, limited numbers of highly trained and skilled fistula surgeons prevent women and girls with fistula from getting timely quality care they need.
- Data – Though efforts are being made, the availability of robust and comprehensive data still remains a challenge in most countries due to weak data systems to report on maternal morbidities and a lack of resources. Countries such as Nepal, Senegal and Uganda have reported weak obstetric fistula data recording and reporting systems.
- A limited number of highly trained, skilled and practicing Obstetric Fistula/PFD surgeons (Afghanistan, Bangladesh, Guinea, Guinea-Bissau, Kenya, Somalia, and Zambia);
- Challenges in the integration of services from different sectors: education, health, justice and social sectors to provide comprehensive response for women and girls affected;
- Lack of active and meaningful participation of affected women and girls in the design of polices, implementation of services and monitoring and evaluation of programmes;
- Lack accountability and redress mechanisms in cases of rights violations and policy failures.

Lessons learned

- High level political commitment and increased investment and action is key to ending fistula by 2030 (at global, regional, national and sub-national levels);
- Partnership and collaboration with other international groups as per the Global Campaign to End fistula, provides excellent opportunities for global, regional and national advocacy and development of national capacities in prevention and treatment of fistula, as well as social reintegration of fistula survivors;
- National ownership and government funding are crucial to a sustainable fistula programme;
- Technical and financial support from the international community remains important for fistula-affected countries to eliminate obstetric fistula within a decade;

- Addressing the interlinkages between poverty, gender discrimination, lack of education of young women and girls and lack of access to health as root causes of obstetric fistula is needed to address this issue;
- Investments to strengthen health systems, including in the areas of data and surveillance systems, quality of care, facility capability, associated emergency medical services and the development of a skilled health workforce, including midwives, are key to maternal and newborn health;
- Strengthening public-private partnership helps ensure that every woman in need of fistula-related services and follow-up is reached;
- Advocacy campaigns and coordination meetings ensure coordination, information sharing, and agreement amongst different stakeholders;
- The involvement of religious and traditional leaders, as well as the creation of awareness about fistula, are crucial strategies to prevent fistula.