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Maternal Health and Human Rights: National and Global Perspectives

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1) Introduction

Every day, approximately 800 women die from complications related to pregnancy and childbirth.[1] In 2010, a shocking 287,000 women died of such complications. Ninety-nine percent of these deaths occur in developing countries, where a woman has a one in 150 chance of ultimately dying from a pregnancy or childbirth-related cause.[2] Severe bleeding after birth, infection due to poor hygiene, untreated high blood pressure, or unsafe abortion cause approximately eighty percent of these deaths. [3] Most of these women could be saved if only governments possessed the financial capability and the political will to make maternal health a priority.

In an attempt to build awareness of these issues, foster collaboration among experts from different fields, and explore possible solutions, Georgetown Law's Human Rights Institute and O'Neill Institute for National and Global Health Law, in partnership with Amnesty International USA and the Center for Reproductive Rights, convened a conference in April 2012 to explore the subject of maternal health and human rights. This event brought together government representatives, nurse-midwives, attorneys, human rights scholars, and some of the most committed advocates and service providers to exchange ideas and work on the issue of maternal health and human rights. This paper provides an overview of the discussion that ensued that day.

Part Two of this document provides an overview of the human rights framework applicable to maternal health. Part Three offers a summary of some of the key barriers to adequate maternal health in developing countries. Part Four focuses on the salient barriers to maternal health in the United States. The document concludes with recommendations for how to better promote and protect women's right to maternal health.

[1] World Health Organization, Maternal Mortality, Fact Sheet No. 348, May 2012, available at http://www.who.int/mediacentre/factsheets/fs348/en/index.html.

[2] A woman's lifetime risk of maternal death is measured as the probability that a 15 year old woman will eventually die from a maternal cause. The chance of dying of a pregnancy or childbirth-related case is 1 in 3800 in developed countries. World Health Organization, Maternal Mortality, Fact Sheet No. 348, May 2012, available at http://www.who.int/mediacentre/factsheets/fs348/en/index.html.

[3] The remaining 20% of maternal deaths are caused primarily by diseases such as malaria and AIDS. World Health Organization, Maternal Mortality, Fact Sheet No. 348, May 2012, available at http://www.who.int/mediacentre/factsheets/fs348/en/index.html.

2) Human Rights Framework

Maternal health is a human rights issue that implicates the rights to life, health, equality, non-discrimination, privacy, freedom from cruel or degrading treatment, and enjoyment of the benefits of scientific progress, among others. Framing maternal health as a human rights issue is useful for practical reasons, as it provides benchmarks against which government action, or inaction, may be measured. It is also important on a higher level: identifying something as a human right acknowledges that an entitlement exists by virtue of being human.

Governments must respect, protect, and fulfill all human rights. The obligation to *respect* means that a government may not interfere directly with a person's enjoyment of his or her human rights. The obligation to *protect* requires that the government take the necessary measures to prevent third parties from infringing on those rights. Finally, the obligation to *fulfill* requires that the government take affirmative steps to ensure that its people are able to enjoy their rights in practice.

Among many other rights, all women have the right to the highest attainable standard of health during pregnancy and childbirth.[4] To respect this right, governments must "refrain from interfering directly or indirectly with the enjoyment of the right to health."[5] They must also "refrain from obstructing action taken by women in pursuit of their health goals," report on the extent to which healthcare providers, public and private alike, are meeting their duties to respect the rights of women to access health care, and ensure that laws do not criminalize "medical procedures only needed by women" or "punish women who undergo those procedures."[6]

With regard to the obligation to *protect* the right to health, governments must "take action to prevent and impose sanctions for violations of rights by private persons and organizations."[7] This

[4] Article 25 of the Universal Declaration of Human Rights establishes not only that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including … medical care," but also that "[m]otherhood … [is] entitled to special care and assistance." See Universal Declaration of Human Rights [UDHR], Art. 25(1) and 25(2). See also the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as well as the obligation of states to take the necessary steps to reduce "the stillbirth-rate and … infant mortality" and to create the "conditions which would assure to all medical service and medical attention in the event of sickness." International Covenant on Economic, Social and Cultural Rights (CESCR), Art. 12(1), 12(a), 12(c). Finally, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) contains numerous provisions that apply to various aspects of maternal health—from healthcare to having access to education to being able to participate in the making of relevant public policies.

[5] CESCR General Comment No. 14, ¶ 33.

[6] CEDAW General Recommendation No. 24, ¶ 14.

[7] CEDAW General Recommendation No. 24, ¶ 15. Additionally, it is worth noting that according to the Committee on Economic, Social and Cultural Rights, obligations to protect to include, among others, "the duties of States to adopt legislation or to take other measures ensuring equal access to healthcare and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents

includes enacting and effectively enforcing laws that prohibit the marriage of girls,[8] as well as ensuring adequate protection and health services for women in especially difficult circumstances, such as women refugees and those in armed conflict.[9]

Finally, with regard to the obligation to *fulfill* the right to health, governments must "take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care."[10] High maternal mortality and morbidity rates across the world reflect violations of this particular right.

Taking a deeper look at the legal framework, the right to the highest attainable standard of health has four principal elements: availability, accessibility, acceptability, and quality.[11] *Availability* refers to ensuring that a sufficient number of public health and healthcare facilities, goods, services, and programs are available to affected women. While it is understood that certain factors, such as the developmental level of the country, will inevitably affect the nature of the facilities, goods, services, and programs provided, governments must, at the very least, ensure that they provide what have been termed "the underlying determinants of health." These include, among others, "safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the World Health Organization (WHO) Action Programme on Essential Drugs."[12] In fact, the WHO's essential drugs list includes medicines and devices necessary for maternal health, such as contraceptives, medicines for the prevention and treatment of HIV/AIDS, and medicines for a healthy pregnancy and delivery.[13] For example, misoprostol, which is used for the prevention of postpartum hemorrhage (a major cause of maternal mortality), is included in the list.[14]

In addition, the government must ensure that health facilities, goods, and services are *accessible* to women without discrimination, particularly vulnerable and marginalized populations of women, such as those belonging to ethnic minorities and indigenous populations and those living with disabilities or with HIV/AIDS.[15] Additionally, "accessibility" includes *physical* and *economic accessibility*. *Physical accessibility* refers to having health facilities, goods, and services that are safely and physically reachable for all women, especially those who are vulnerable or marginalized. Health facilities, including those in rural areas, must also guarantee accessibility to medical services and the underlying determinants of health. *Economic accessibility* refers to ensuring that facilities, goods, and services are affordable to all, including

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and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services" (CESCR General Comment No. 14, ¶ 35).

[8] CEDAW General Recommendation No. 24, ¶ 15 (d).

[9] Id.

[10] CEDAW General Recommendation No. 24, ¶ 17. See also CESCR General Comment No. 14, ¶ 33, which makes clear that governments must "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health."

[11] CESCR General Comment No. 14, ¶ 12.

[12] CESCR General Comment No. 14, ¶ 12(a).

[13] See Word Health Organziation (WHO), The Interagency List of Essential Medicines for Reproductive Health (2006), available at http://whqlibdoc.who.int/hq/2006/WHO_PSM_PAR_2006.1_eng.pdf, 1.

[14] WHO, WHO Model List of Essential Medicines, available at: http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf.

[15] CESCR General Comment No. 14, ¶ 12(b).

those who are economically disadvantaged. Determinations of payment, regardless of whether the services were provided by the private or public sector, must be based on the principle of equity. Finally, accessibility also requires that women be guaranteed the right to seek, receive, and impart information and ideas with regards to maternal health.[16] Moreover, women's right to have their personal data kept confidential must be respected.[17]

The element of *acceptability* requires that all health facilities, goods, and services respect medical ethics and be "culturally appropriate." This means that they must respect the culture of individuals, minorities, peoples, and communities. They must also be sensitive to gender and age, as well as ensure confidentiality and improve the health of patients.[18]

Finally, the element of *quality* requires that health facilities, goods, and services be "culturally acceptable," as well as "scientifically and medically appropriate and of good quality." This means that there must be, *inter alia*, "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation," all of which are essential to maternal health.[19]

In addition, according to the UN treaty bodies tasked with interpreting this right, governments must also adopt "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."[20] They must also establish sexual and reproductive health education for both male and female adolescents, including information on family planning,[21] and report on measures adopted to guarantee "timely access to the range of services which are related to family planning."[22]

Finally, governments must report "on measures taken to eliminate barriers that women face in gaining access to healthcare services and what measures they have taken to ensure women timely and affordable access to such services." These barriers include "requirements and conditions that prejudice women's access such as high fees for healthcare services, the requirement for preliminary authorization by a spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport."[23] Governments must report on what they have done to guarantee access to quality healthcare services, which should include making them acceptable to women. These services are to respect a woman's right to dignity and full informed consent, guarantee her confidentiality, and be "sensitive to her needs and

[16] See CESCR General Comment No. 14, ¶ 12(b). In a similar vein, the CEDAW Committee has also emphasized the right of women to be fully informed by "properly trained personnel" upon the agreement of treatment. Such information should include information on the "likely benefits and potential adverse effects … and available alternatives." See CEDAW General Recommendation No. 24, ¶ 20.
[17] CESCR General Comment No. 14, ¶ 12(b).
[18] CESCR General Comment No. 14, ¶ 12(c).
[19] CESCR General Comment No. 14, ¶ 12(d).
[20] The Committee on Economic, Social and Cultural Rights has called the provision "the right to maternal, child and reproductive health."CESCR General Comment No. 14, ¶ 21.
[21] CEDAW General Recommendation No. 24, ¶¶ 18, 23.
[22] CEDAW General Recommendation No. 24, ¶ 23.
[23] See CEDAW General Recommendation No. 24, ¶ 21.

perspectives." States are to ensure that women using these services are not subject to coercion that violates their rights to informed consent and dignity, such as non-consensual sterilization.[24] Furthermore, "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services;" these services should be allocated to "the maximum extent of available resources."[25] Therefore, governments should report on "measures taken to ensure women appropriate services in connection to pregnancy, confinement and the post-natal period," as well as information on how these measures "have reduced maternal mortality and morbidity" in the general population and in vulnerable groups, regions, and communities. Considering the link between the risk of death or disability faced by women and the lack of resources allocated to providing necessary services, governments must also report on the extent to which they provide "free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women."[26]

[24] See CEDAW General Recommendation No. 24, ¶ 22.
[25] See CEDAW General Recommendation No. 24, ¶ 27.
[26] See CEDAW General Recommendation No. 24, ¶ 27.

3) Barriers to Maternal Heath Care: Global Issues

This section describes some of the key barriers to adequate maternal health in developing countries, where ninety-nine percent of maternal deaths occur.[27] These deaths, as well as other maternal health problems, are due to at least three key factors. First, women in too many countries are not socially or economically empowered to fight for their rights. Second, the countries themselves lack adequate infrastructure to care for these women. Third, too many women are denied the dignity and respect they are owed. As a result, the needs of mothers and soon-to-be mothers around the world are unmet, often with tragic consequences.

a. Lack of Empowerment

Around the world, too many women and girls are forced into early marriage, denied access to family planning options, and treated as second-class citizens. Ultimately, their lack of social and economic empowerment leads to poor maternal health.

Several conference participants identified early marriage as one of the key causes of poor maternal health. One panelist explained that early marriage forces girls to bear children "too early and too often." Many girls marry much older men and have no control over the frequency with which they engage in sexual intercourse or the spacing of their children's births. As one panelist noted, in Ethiopia, forty-three percent of girls marry before age fifteen, forty-five percent of girls ages fifteen to nineteen are illiterate, and seventy percent of girls surveyed by the participant's organization have their first sexual encounter within marriage before their first menstrual period. According to the WHO, pregnancy and childbirth-related complications are the leading cause of death of teenage girls in most developing countries.[28]

Conference participants made clear that maternal health is put at risk where women and girls face discrimination. The situation is often made worse when combined with a lack of access to (1) basic family planning methods that limit and delay child bearing, (2) safe abortion services, and (3) emergency obstetric care in cases where complications arise. One speaker noted that in Uganda, where men have the right to marry multiple women, there exists a restrictive abortion law and a lack of good access to contraception. The speaker highlighted that Uganda has one of the highest fertility rates in the world (6.1 births per woman in 2010[29]). Additionally, in conflict zones like Darfur, women who are victims of sexual violence and rape face stigma and risk being disowned by their families, shunned, and judicially prosecuted; they are also often unable to access post-exposure contraception.

More broadly, lack of education about sexual and reproductive health is also a serious problem and an important contributing factor. Conference participants noted that women's lack of participation in drafting and enforcing their countries' laws also contributes to poor maternal

[27] WHO, Maternal Mortality Fact sheet No. 348, May 2012, available at: http://www.who.int/mediacentre/factsheets/fs348/en/index.html.
[28] Id.
[29] The World Bank, Fertility rate, total (births per woman), available at: http://data.worldbank.org/indicator/SP.DYN.TFRT.IN.

health outcomes. To address these problems, participants suggested enhancing women's and girls' access to education and family planning options, incentivizing their delay of marriage and childbirth, and empowering them with knowledge of the rights they are due.

b. Lack of Physical Infrastructure

Conference participants made clear that in too many places around the world, maternal health is at risk because there is a dearth of skilled healthcare providers, hospitals are in poor condition and experience frequent shortages of lifesaving medicines and supplies, maternal healthcare is not affordable, and many women do not have access to transportation to take them to healthcare facilities.

Regarding the lack of skilled and knowledgeable healthcare professionals in countries around the world, one speaker highlighted that sub-Saharan Africa is home to thirteen percent of the world's population, but just three percent of the world's healthcare professionals; this disparity has real-life consequences, as fifty percent of the world's maternal deaths take place in that part of the globe. Another participant stated that, in Ethiopia, a population of eighty-two million people is served by only 104 obstetrician/gynecologists (half of whom are not even practicing). Moreover, most of these physicians are concentrated in urban areas, though eighty percent of the country's inhabitants live in rural areas.

Beyond the numbers, conference participants expressed concern about the knowledge and skills of existing healthcare providers. Many of these providers simply do not have the training or equipment to prevent infection, treat hemorrhage, or even counsel women in pregnancy and childbirth. And those doctors, nurses, and other skilled professionals who do have the background to properly assist women in pregnancy and childbirth often seek opportunities abroad, making "brain drain" a serious barrier to adequate maternal care.

In addition to being poorly staffed, hospitals and clinics in many parts of the world are themselves too often left in extremely poor condition. Speakers discussed the prevalence of filth and mold; one told of bats living in a clinic roof and dropping feces on women. Such lack of adequate hygiene leads to infection, a major cause of maternal death. Additionally, the facilities often lack the drugs, supplies, and equipment women need before, during, and after childbirth. Participants spoke of chronic shortages of blood, medicines, transfusion bags, sutures, gloves, syringes, scissors, disinfectant, sheets, blankets, and even soap. One speaker described a study that noted that two-thirds of healthcare facilities in Kenya lacked scissors and disinfectant. She also told of women being forced to give birth on the floor or, if on a bed, atop stained and filthy mattresses.

Finally, many women and their families are forced to pay for the services and supplies they are provided, and all too often the expense is prohibitive. One conference participant noted that some men reason that it is cheaper to pay for another wife than it is to pay for a life-saving cesarean section.

Despite the challenges that come with receiving treatment at these healthcare facilities, those women who are able to reach any healthcare provider or facility at all are the lucky ones. For

many people, especially those living in rural areas, the lack of decent roads and transportation options makes getting to hospitals and clinics nearly impossible. Conference participants spoke of women arriving at clinics by foot or by donkey after days of obstetrical distress. Too often, these barriers lead to poor outcomes for maternal health.

c. Lack of Dignity and Respect

All too often, women and girls are not afforded the respect and dignity they deserve; they are discriminated against when it comes to healthcare, they are not provided the information or agency they need to make informed health-related choices, and they suffer poor maternal health outcomes as a result. While "respectful treatment, free of abuse" sounds elemental, many participants agreed that it is a right that is violated all too frequently. Making matters worse, when word of such mistreatment gets around a community, other women may refrain from seeking professional medical care in the future.

Conference participants spoke of women being verbally—and sometimes even physically and sexually—abused by maternal healthcare providers. Citing a report by the Center for Reproductive Rights called, "Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities," one conference participant recalled the story of a woman in Kenya who, while giving birth, was told by a healthcare professional, "Did I send you here? Spread your legs the way you did when you got pregnant. That day you did not scream, but today you are screaming at us."[30] Participants noted that treatment like this not only has the effect of dis-incentivizing women from accessing maternal healthcare in the future, but it also has the much more widespread effect of discouraging the female community as a whole from seeking *any* type of medical help in the future.

Conference participants also discussed the importance of both confidentiality and the ability of women to receive all the information necessary to make informed decisions about their medical care. Frequently, because of gender discrimination, such medical decisions are not made by the women themselves, but by male relatives. In other cases, healthcare professionals believe the woman is unable to make informed decisions either because of her age, ethnicity, or economic status, and may deny her information and/or make medical decisions for her.

To address these problems, conference participants discussed the need for protocols that would articulate the interpersonal care women are due. They highlighted the need to train healthcare workers, and to ensure their adequate supervision.[31] They spoke about the need for maternal death audits, both to collect data on these tragic events and to better understand how the healthcare system is flawed. Finally, at a more general level, conference participants noted that

[30]Center for Reproductive Rights and Federation of Women Lawyers–Kenya, 31 Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities 2007, available at http://reproductiverights.org/en/document/failure-to-deliver-violations-of-womens-human-rights-in-kenyan-health-facilities.

[31] Speakers noted that in many cases healthcare workers feel their own rights have been violated because they work in very poor conditions and have a heavy workload, a lack of access to medicines, and poor physical infrastructures that do not allow them to complete the task to the best of their abilities. As such, improving the conditions in which healthcare workers perform their functions is also very important.

when women and girls are empowered and know their rights, they are better able to demand that they be treated with dignity and respect.

Women at Risk

Women at risk—including those living in conflict and post-conflict situations, those who are migrants or refugees, those from indigenous communities, and those in prison—may be particularly vulnerable when it comes to maternal health. [32] Although there is little data on maternal health in situations of conflict, the information that is available shows higher levels of maternal mortality.

Conference participants noted that women in situations of risk often have different needs when it comes to maternal healthcare and they should receive treatment specific to their situation. They underscored the need to consult with pregnant women in these vulnerable situations in order to understand their needs and the changes that could improve their maternal health. For instance, refugee women have expressed their apprehension of cesarean births, and concern about the competence of medical interpreters.[33]

[32] In the opening statement of the fifty-fifth session of the Committee on the Elimination of Discrimination against Women, Ms. Silvia Pimentel, Chairperson, said that the committee is "increasingly concerned with the particular vulnerability of women at risk, such as women in armed conflict and post conflict situations, migrant and refugee women, and indigenous women." Commission on the Status of Women, Fifty-fifth session, 22 February to 4 March 2011, Statement by Ms. Silvia Pimentel, Chair Committee on the Elimination of Discrimination against Women. Available at: http://www2.ohchr.org/english/bodies/cedaw/docs/statements/StatementChairCSW55thsession2011.pdf In other occasions, the Committee has also included women in prison as part of women at risk groupings.

[33] Somali Health Initiative, Minnesota International Health Volunteers, Minneapolis, J. Midwifery Women's Health, 2004.

4) Barriers to Maternal Health Care: U.S. Issues

In 2011, the United States ranked fiftieth on a list ranking countries' rates of maternal mortality, below almost every European country. Two to three women die giving birth in the United States every day, and there are twenty-one maternal deaths for every 100,000 live births.[34] (By contrast, the rate in the United Kingdom is twelve maternal deaths for every 100,000 live births). Furthermore, while in many countries maternal mortality is on the decline, the United States has seen a startling increase in maternal mortality over the past two decades. At the same time, the United States spends twice as much as any other country on childbirth-related medical care,[35] an indication that its barriers and problems are very different from those experienced in the developing world.

Conference panelists outlined several factors that contribute to these disheartening statistics. First, women are denied the necessary information and the opportunity to make choices regarding what technical interventions are best for them. Second, the government does not collect adequate data about the problems women face in obtaining maternal health care. Finally, poor and minority women are disproportionately disadvantaged when it comes to enjoying adequate maternal health care.

a. Lack of Education and Choice Regarding Technical Interventions

Many women in the United States enjoy access to advanced, life-saving technologies and procedures during their labor and delivery experience. Acknowledging this reality, several conference participants described a paradox: in some cases, the over-use of medical interventions in labor and delivery contributes to greater maternal health risks and preventable maternal deaths. They attributed this not to any inherent defect in the medical tools and techniques, but rather, to factors other than fully informed woman-centered decision-making which influenced whether or not technical interventions were employed.

Conference participants highlighted the use of cesarean sections as a paradigmatic example. While cesareans are in many cases a necessary, life-saving procedure, and access to them is a vital component of adequate maternal health, several speakers expressed concern over the rate of cesareans in the United States. Indeed, one third of women giving birth in the United States today undergo surgery in order to give birth,[36] permanently altering their reproductive health. Participants spoke of adhesions that cause pain for the rest of women's lives, infection, hysterectomy, and abnormal placental implantations in subsequent pregnancies, which can lead

[34] Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA, World Bank. Available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

[35] Amnesty International, 4 Deadly Delivery: The Maternal Health Care Crisis in the USA: One Year Update, 2011, available at http://www.amnestyusa.org/sites/default/files/deadlydeliveryoneyear.pdf.

[36] The U.S. Institute of Medicine and Center for Disease Control agree that current rates of cesarean section in the United States are too high. See Deadly Delivery, One Year Update. Amnesty International, 8 Deadly Delivery 2011. The World Health Organization recommends that cesareans be used in somewhere between five and fifteen percent of live births. In 1995, the rate was 20.7 percent, and it has increased every year since, until in 2009 it was reported at 32.9 percent, and is in some states is just under 40 percent. See Amnesty International, 9 Deadly Delivery 2011.

to additional unnecessary maternal deaths, valve obstructions, and kidney problems. Moreover, cesareans carry a greater risk of complications and death compared to vaginal deliveries.

There is concern that the prevalence of cesarean procedures in the U.S. reflects factors other than the fully informed decision-making of American women. According to Amnesty International, cesareans are more expensive than vaginal births, and the rates are highest for women with private health insurance, second-highest for women with government health insurance, and lowest for women who have no insurance at all—suggesting that cesareans may be used more often than medically necessary in situations where there is a reasonable expectation of full payment for the more expensive procedure.[37]

Conference participants also noted that induction of labor is frequently employed without ensuring that women have full knowledge of the risks associated with induction, and without being offered alternatives. Induction is associated with increased rates of hemorrhage, which is a major cause of maternal death in the United States.

Finally, conference participants highlighted the fact that the United States, like countries all over the world, continues to struggle with access to basic sexual education and contraception, which is also an essential component to autonomous decision-making and maternal health.

To address these problems, speakers emphasized that women need to be empowered with the available information to make the best choices for themselves and their health. Women themselves, and not insurance companies or high-level healthcare policymakers should make health-related decisions.

b. Lack of Adequate Data

The United States does not keep detailed data on which techniques are effective or ineffective in improving women's health care, why and how women are dying in childbirth, and possible problems in the provision of quality care. One conference participant pointed out that there is no survey for the U.S. on maternal death, and that, even when data on maternal health issues *is* available, the numbers are usually four to seven years old. Without an adequate feedback system, clinicians do not know enough about the causes of maternal mortality to effectively reduce them. Conference participants therefore emphasized the need for data on why women die in childbirth, and stressed that this information should be collected in a way that allows practitioners to begin spotting patterns, creating methods to counter them, and developing the political will and the economics resources to do so.

For example, one conference participant noted that while hemorrhage is a common cause of maternal mortality in the United States, there is no consistent method for recognizing when a woman is bleeding too much, nor is there a consistent practice on how to respond when a hemorrhage is detected. Without clear data on what methods are being used and what the outcomes are, there is no way to develop better and more effective methods.

[37] Deadly Delivery, One Year Update. Amnesty International 2011, page 9 http://www.amnestyusa.org/sites/default/files/deadlydeliveryoneyear.pdf

Participants tied the lack of effective data collection to the overuse of technical interventions mentioned above. While many practitioners assume that better, more advanced technologies lead to safer labor and delivery, rigorous data is necessary to determine whether that is, in fact, the case.

c. Disparate Maternal Health Outcomes

The United States suffers from extreme inequities in maternal health, with statistics showing disparities among racial groups, income groups, and geographic locations. African American women face a staggering maternal death rate of thirty-four deaths per 100,000 live births, making them three to four times more likely to die in childbirth than Caucasian women; this statistic holds true even when you compare Caucasian and African American women from low-, middle-, and high-income levels.[38] Even worse, African American women are five times more likely to die in childbirth if they face a high-risk pregnancy. Increased risk of maternal death was also observed for American Indian/Alaskan Native women, and Asian/Pacific Islander women.[39] Moreover, across the United States, women living in low-income areas are twice as likely to die in childbirth, while women in middle-income areas are fifty-eight percent more likely to die in childbirth, when compared to women in higher-income areas.[40]

Conference participants pointed out that these statistics show extreme inequalities in access to healthcare, including pre-natal healthcare, which is a major factor in predicting maternal health and morbidity. Women with no prenatal care are three to four times more likely to die in childbirth, and African American and Latina women are 2.5 times more likely to receive late or no prenatal care than Caucasian women.

Shackling of Women in Prison

Conference participants discussed the shackling of pregnant women in U.S. prisons, a population that is particularly vulnerable. Federal regulations have been revised to restrict the shackling of women during labor[41] and changes in immigration policies regarding the treatment of detainees state that restraints are not permitted on women in active labor or delivery.[42] Still, many states continue to permit the shackling of women in state prisons during childbirth.

5) Conclusion and Recommendations

[38] Id. at 7.
[39] Id.
[40] Id.
[41] Leveille, Vania, "Bureau of Prisons Revises Policy on Shackling of Pregnant Inmates." Blog of Rights, ACLU, http://www.aclu.org/blog/content/bureau-prisons-revises-policy-shackling-pregnant-inmates.
[42] ICE: Performance-Based National Detention Standards 2011 (April 2012). Available at http://www.ice.gov/doclib/detention-standards/2011/medical_care_women.pdf.

While this conference highlighted a broad range of issues, all of which are influenced by local realities, a number of themes were repeatedly discussed. Critically, all women must have access to comprehensive health services without discrimination. Conference participants identified the key services as primary care, reproductive health education, contraception, safe abortion, and pre-natal and post-natal care. These services must be legal, provided by well-trained and supervised healthcare professionals, and affordable for all.

Laws that criminalize any of the healthcare services identified above, or criminalize them in certain cases—such as in the absence of consent from husbands—impede women's access to the maternal healthcare to which they are entitled. As such, conference participants said, governments should legalize and affirmatively incentivize the expansion of maternal healthcare services.

Training healthcare providers was also discussed as an important way of expanding and increasing the quality of women's healthcare services. Conference participants recommended establishing training programs for healthcare workers who are already accessible to women in need[43] and providing accountability for and oversight of these professionals.[44] Trainings should focus on providing healthcare that is women-centered; in all cases, training should emphasize the need to treat women with dignity. [45] Ultimately, the provision of adequate training will only be fully possible once there is greater knowledge about the methods and practices that most greatly impact maternal health outcomes. As such, maternal health-related data must also be collected.[46]

Finally, maternal healthcare must be affordable for all. Globally, the issue of affordability of healthcare services is tied to the recognition of maternal health as a human right that states have the obligation to fulfill. Advocates should develop the human rights framework in support of that right in order to make clear to states that they have an affirmative obligation to provide accessible, affordable healthcare services to women and mothers.

The involvement of women is essential to developing and implementing the above recommendations. Efforts to involve women should emphasize connecting with and empowering all women, but most especially those most deeply affected by large-scale deficiencies in maternal healthcare services—women who live in poverty, racial minorities, migrant women, and women who live in indigenous communities. Women, particularly the most marginalized populations, must be empowered to know their rights; they will then be able to act as their own advocates and to demand the standard of care they are due. Involving women from many backgrounds in the policy-making process—that of crafting laws and pursuing their implementation—will help

[43] One conference participant discussed a training program in India for auxiliary nurse-midwives, who are often the only point of contact for women in rural parts of the country. The improved certification allowed them to provide life-saving IV injections and medications that they were not previously authorized to administer, and the program effectively expanded access to essential healthcare for women all over India.

[44] Because healthcare workers are allies in the struggle for women's health, this oversight should, when possible and appropriate, take place in a spirit of cooperation, take the tone of support, and have a forward-looking resolution.

[45] For information about the principle of respectful maternity care, see http://www.whiteribbonalliance.org/WRA/assets/File/Final_RMC_Charter.pdf

[46] In the United States, the Conyers Maternal Health Accountability Act was proposed in 2011 to accomplish that goal. http://www.govtrack.us/congress/bills/112/hr894.

ensure that the resulting policies are responsive to the authentic needs of women and are sensitive to their actual struggles and challenges.

Finally, conference participants stressed that there must be accountability at the national level, and states must be held responsible if they fail to fulfill their obligation to uphold women's right to health. To this end, the push to shore up and explicate the international legal obligations of states with regard to the right to maternal health should be continued and expanded.[47] At the state level, countries must work to incorporate these international legal obligations into their domestic law.[48] Ultimately, further developing these international and domestic legal obligations is essential to winning the fight for women's health.

[47] Positive developments toward this end include the April meeting of the Inter-Parliamentary Union which focused on developing a more specific framework for national obligations under the right to maternal health (see http://wrauganda.blogspot.com/2012/04/historical-commitment-from-inter.html), as well as the development and ratification of the Maputo Protocol (http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf) an African human rights treaty which establishes state obligations to provide pre-natal and post-partum care. International courts also have an important role to play, as evidenced by a decision the CEDAW Committee issued last year. In Alyne da Silva Pimentel Teixeira (deceased) v. Brazil, CEDAW, UN Doc. CEDAW/C/49/D/17/2008 (10 August 2011), the Committee found that, "governments have a human rights obligation to guarantee that all women in their countries—regardless of income or racial background—have access to timely, non-discriminatory, and appropriate maternal health services. Even when governments outsource health services to private institutions, they remain directly responsible for their actions and have a duty to regulate and monitor said institutions." See http://reproductiverights.org/en/document/decision-alyne-da-silva-pimentel-v-brazil.

[48] One conference participant noted that in both Nepal and Tanzania, governments are working on domestic legislation to guarantee women's right to health generally, and reproductive health specifically. Similarly, in Kenya, efforts are under way to match the rights contained in the Respectful Maternity Healthcare document with the rights protected under the Kenyan constitution. These kinds of efforts are especially vital in the United States where, in addition to the reluctance to ratify international treaties, the notion of rights generally refers to the obligation of states to refrain from harmful conduct, rather than an affirmative obligation to fulfill economic, social, and cultural rights.