Women Who Die Needlessly: Maternal Mortality as a Human Rights Issue

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Introduction

Giving birth is a unique event. Apart from being a crucial physiologic process for mother and child, it is a psychological, social and sociological phenomenon. If it is a first birth for a young and recently wed girl, she becomes a mother, of a different and elevated status. In some societies this status is further enhanced if the newborn is a male. In ordinary circumstances, the birth of a child means that the family and society embrace a new member. Everywhere, rich traditions surround this important life event, and contribute to the attention and care that the mother and child will get. Some traditions are positive, while others may be dangerous.

The physiologic process is also dramatic. For the baby, the transition from living on oxygen and nutrients supplied by the umbilical cord to breathing on one’s own, and receiving nourishment through breastfeeding, is a feat comparable to an astronaut’s landing on the moon. For the mother, we know that pregnancy and birth, the familiar and natural process of reproducing humankind, nonetheless entail danger—a 15 percent risk of developing potentially life-threatening complications, and a one to three percent risk of death if no maternal health care is available (WHO 1999).

While learning that one is pregnant is good news for many women, it is not so for many others. Many pregnancies are unplanned and unwanted, due to lack of knowledge, lack of contraceptives or sexual coercion. An unsafe abortion may be the outcome instead of a joyous birthing event.

Women who cannot choose when to have sex, whether to use protection or lack access to contraceptive information and affordable services, or—once they are pregnant—lack access to basic...
maternal health care, are the ones who die of pregnancy-related causes. In many countries, they have no access because health care is not in place due to geographical, infrastructure, or financial constraints, or because of constraints imposed by their partners or families. They are dying because they are women, and societies are not giving enough attention to saving them.

A human rights strategy can help increase the long-overdue emphasis on women’s right to choose when to have a child and to experience safe motherhood, by increasing government accountability to provide adequate reproductive health (RH) services. Using a human rights approach can also increase public demand for providing girls and women with education, adequate nutrition, basic health care and the autonomy to use it and to make their own choices. Women and girls are all too often the ones who eat last and least in families. Stunting due to severe malnutrition in childhood increases risk of obstructed labor in women, due to cephalopelvic disproportion (small pelvis). Severe anemia increases the risk of infection during pregnancy and childbirth, death from hemorrhage, and death or complications if a cesarean delivery (operation) is needed. Other micronutrient deficiencies (vitamin A, iodine, and calcium) also are associated with increased risk of complications or death (WHO 1999).

The vast majority of those who die from maternal causes are poor women of the developing world; they are usually uneducated and many live in remote areas. Many are not permitted to seek medical care and in any event, most cannot afford user fees, and fear going to health services lest the cost of a prescribed medical intervention bring about the economic ruin of the family. This inability or reluctance to access health care results in dangerous delays for many women. A framework developed by Deborah Maine of

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**How does women's lower status in society affect maternal mortality?**

**Women are subject to:**

**Limited education and exposure to accurate information:** In much of Africa and Asia, 75 percent of women age 25 and over, are illiterate. When girls are denied schooling, as adults they tend to have larger families and poorer health. The children of uneducated women also face a higher risk of death. Women who cannot read or access other sources of information are unable to learn about healthy pregnancy and delivery. Pregnancy is not seen as a condition requiring special care, and women do not recognize danger signs during pregnancy. Even if they are experiencing prolonged pain and suffering, they may have been taught that this is a woman’s lot and therefore do not seek medical care.

**Limited decision-making:** In many developing countries, men make the decisions about whether and when their wives (or partners) will have sex, use contraception or bear children. Frequently husbands deny women access to antenatal care, especially if household money is to be spent on it. In many places, husbands, other family members, or elders in the community also decide where a woman will give birth and must give permission for her to be taken to a health facility.

**Limited resources:** Poverty, cultural traditions and national laws restrict women’s access to financial resources and inheritance in the developing world. Without money, they cannot make independent choices about their health or seek necessary services.

**Health services insensitive to their needs or staffed by rude providers who do not offer them real choices:** In many cultures, women are reluctant to use health services because they feel intimidated and humiliated by health workers, or pressured to accept treatments that conflict with their own values and customs (Koblinsky et al. 1999).
Columbia University describes different types of delays that can result in maternal death:

- Delay in deciding to seek care, since women and family members may not recognize the complication, and may not take immediate action even when it is recognized.
- Delay in reaching appropriate care, since the transport and/or referral systems may not be available or affordable.
- Delay in receiving care at facilities, depending on the quality of facilities and staff.

Today, only slightly more than half of the women in the developing world (53%) have access to skilled attendants at birth; this percentage has risen little from its 1990 figure of 51 percent. The number of women who wish to delay or stop childbearing but do not use contraception is still large, estimated at 150 million. Moreover, millions of women lack access to safe abortion services. These challenges remain and are intertwined with the challenges of improving women’s status and rights, including the rights to equal access to education, job opportunities and political participation.

**Obstacles to Safe Motherhood**

Providing basic maternal health services for all pregnant women is a huge challenge. In countries ravaged by war, civil unrest or natural disasters, the situation is especially difficult. More common, however, is the challenge for poor developing countries to strengthen their health systems in order to provide both skilled birth attendants and district hospital back-up for complications. This is a major challenge for countries with limited coverage of care, particularly in rural areas. Many countries struggle with the administrative and logistic difficulties in coordinating different levels of care, (e.g., the skilled birth attendant, who usually works at a local health center, and the district hospital to which women may be referred for complications). A third challenge is to make existing services economically accessible, while maintaining both quality and sustainability. User-fee systems need to offer free services (or have voucher or government insurance programs) for the very poor. Recent experience in many countries with user fees shows significant declines in clients of basic maternal health services. Poor families may otherwise choose not to spend meager resources on the “normal” process of birth.

Quality issues are key: if birthing women and their cultural values are not respected at health facilities, and if essential drugs and equipment (e.g., gloves, clean water, soap, antibiotics) are not in place, women rightly prefer to give birth at home in traditional ways. In many parts of the world, skilled professional birth attendants may not be available, and governments may not have the resources to address the situation. While there is no evidence that training traditional birth attendants (TBAs) will in itself, in the absence of other interventions, lead to reduced maternal mortality, we should not assume that there is...
no benefit in training TBAs. There is a need to assess whether the trained TBAs are working within a system that includes adequate supplies, linkages with the health system, transportation, and social as well as economic support for referral services when needed. Outreach programs should also incorporate key decision-makers in the household (such as the mother-in-law) or community leaders who affect the decision to seek emergency care. In sum, TBA training should be part of a broader strategy that includes community education about healthy practices and danger signs, needed equipment and drugs, and functioning referral, transportation, supervision, and evaluation systems (WHO 1999; Starrs 1998). In developing countries, 24 percent of maternal deaths occur during pregnancy, 16 percent during delivery and 61 percent soon after delivery (Dayaratna et al. 2000). Women who are not attended by a skilled provider at birth should be visited by a community health worker within 24 hours of delivery and again within three days of delivery per WHO recommendations.

**Appropriate Approaches: Successful Interventions**

Sri Lanka has one of the lowest maternal mortality ratios (number of maternal deaths per 100,000 live births) in the world despite the general poverty prevalent in that country. Government policies in Sri Lanka have for many years emphasized equity in access to basic needs in infrastructure, health and education. The policies that have helped improve women’s status and thereby reduce maternal mortality are listed below.

- Free education for all and equal educational access for girls, high female literacy, and increased age of marriage for girls are factors associated with the relative high status of women in society.
- Family planning is highly accessible; contraceptive prevalence is high; and the fertility rate is low.
- Antenatal and delivery services are accessible due to good road infrastructure; maternal and child health services are integrated with family planning; and free services are accessible to communities through community-based government facilities. Over 90 percent of women deliver with a skilled attendant in an institution.

Other developing countries have also decreased maternal mortality ratios, through differing models of delivery care. Four models of care are described by Koblinsky et al.:

- Model 1—home deliveries are assisted by a non-professional (rural China, Brazil),
- Model 2—home deliveries are assisted by a professional (Malaysia, 1970s-80s),
- Model 3—deliveries take place at a basic Emergency Obstetric Care (EOC) facility (Malaysia, 1980s-90s, Sri Lanka),
Model 4—deliveries take place in a comprehensive EOC facility (Mexico City, urban China).

The authors point out that “Models 1, 2, and 3 use strong political support and long-term planning as a foundation...there is coordination between all levels of care. In China and Malaysia, the accountability of local officials for performance was a significant management tool. Referral and comprehensive essential obstetric care were free...and require(d) infrastructural investment.” While Model 1 has helped reduce maternal mortality ratios, there is no evidence that the ratio achieved has been under 100 per 100,000 live births, whereas Models 2-4 can achieve a ratio of 50 or lower. However, Model 4 does not necessarily reduce the ratio below 100, and the authors caution against over-medicalization of delivery.

**Implications and Recommendations**

There is much that needs to be done. The 1994 International Conference on Population and Development pledged to cut the number of maternal deaths in half by the year 2000, and in half again by 2015. However, there has not yet been a significant decline in maternal mortality. This lack of success is due in part to insufficient awareness of the problem and inadequate levels of political commitment. Both political will and resources are needed, as well as the implementation of program strategies that have been proved to be not only the most effective but the most cost-effective as well. Risk-screening during antenatal care, for example, has in recent years been shown to be less effective at reducing mortality than other strategies, since most obstetric emergencies cannot be anticipated. Recommended approaches to change include the following:

**Advocacy for Women, and Advocacy for Safe Motherhood**

There is a need to empower women through human rights education and community action in the short term, and a commensurate need for long-term strategies to increase educational, economic and political opportunities for women. At the same time, there is a continuing need for a specific focus on strategies to reduce maternal mortality. The global Safe Motherhood Initiative began in 1987 with the aim of raising awareness and mobilizing action to reduce maternal mortality. This initiative is sponsored by UNICEF, the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the International Planned Parenthood Federation (IPPF), the World Bank, and the Population Council, and has been increasing the attention and commitment to safe motherhood.
through conferences, influencing policy and program activities, and raising funding levels for safe motherhood programs internationally.

More recently another advocacy coalition was formed, the global White Ribbon Alliance for Safe Motherhood. It is a group of organizations dedicated to raising international awareness about the need to make pregnancy and childbirth safe for all women and infants. The symbolic white ribbon is dedicated to the memory of all women who have died in pregnancy and childbirth. The White Ribbon Alliance unites individuals, organizations and communities who are currently working to increase public awareness about this needless loss of life and to promote safe motherhood practices and policies (Jejeebhoy 1997). Its approach is to make safe motherhood a more visible issue throughout the world, build partnerships with governments and nongovernmental organizations (NGOs), and develop networks of groups with common goals for more effective collaboration.

Community Action

Sustainability of maternal services can be improved with cost-recovery schemes, and also by involving the community, e.g., by maintaining maternity “waiting homes,” offering housing for midwives, or providing emergency transportation (owners of vehicles get standard reimbursement for transporting women with severe complications to EOC services). These actions demand long-term commitment over years and decades. Such commitment at all decision-making levels in society needs to be fueled and sustained by the growing belief that women are important, necessary and valued. Families and communities simply cannot afford to lose their mothers so often and unnecessarily. There must be understanding that a large percentage of the deaths are preventable with existing resources, and another large proportion can be prevented with small incremental resources.

Another effective strategy to increase local commitment over the years is to highlight individual maternal deaths, by maternal death reviews conducted by concerned community members. Not only health care staff, but also key decision-makers could be made aware of each maternal death that occurs in the community and what might have been done to prevent it; the lessons learned from each death are then used for improvements. This con-

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**International Agreements that Provide Useful Frameworks for Safe Motherhood Advocacy**

- Convention on the Elimination of All Forms of Discrimination Against Women
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Rights of the Child
- European Convention on Human Rights
- American Convention on Human Rights
- African Charter on Human and Peoples’ Rights

Each treaty or convention is monitored by a group that develops performance standards for member countries and tracks compliance through periodic reports provided by each country. Family Care International, an NGO that spearheaded the Safe Motherhood movement, has prepared a summary of these agreements. See their Website at www.familycareintl.org.
sistent highlighting of unnecessary maternal deaths is inter-linked with the relative value and status of women in society. Highlighting easily avoidable maternal deaths can help give attention to the value and importance of women.

**Recommendations of the 1998 Safe Motherhood Technical Consultation in Sri Lanka**

In addition to those listed above, the following recommendations were made at an historic global gathering of those concerned with reducing maternal mortality:

- **Ensure skilled attendance at delivery.** The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of an emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.

- **Delay marriage and first birth.** Reproductive health information and services for married and unmarried adolescents need to be: legally available, widely accessible, and based on a true understanding of young people’s lives. Community education must encourage families and individuals to delay marriage and first births until women are physically, emotionally, and economically prepared to become mothers.

- **Realize the power of partnerships.** Governments, NGOs (including women’s groups and family planning associations), international assistance agencies, donors, and others should share their diverse strengths to promote safe motherhood within communities and across national boundaries. Programs should be developed, evaluated, and improved with the involvement of clients, health providers, and community leaders. National plans and policies should put maternal health into its broad social and economic context, and incorporate all groups and sectors that can support safe motherhood.

- **Prevent unwanted pregnancy and address unsafe abortion.** Program planners should aim to reduce the number of maternal deaths from unsafe abortion by ensuring that all safe motherhood programs include: client-centered family planning services to prevent unwanted pregnancy; contraceptive counseling for women who have had an induced abortion; the use of appropriate technologies for women who experience abortion complications; and where not against the law, safe services for pregnancy termination.

- **Measure progress.** Because it is difficult and costly to estimate maternal mortality accurately, alternative ways of measuring the progress and impact of safe motherhood programs must be used. Since maternal mortality is directly linked to the coverage and quality of maternal health services, information on such indicators as who cares for women during childbirth, where the delivery takes place, and the quality of services at health facilities should be collected and analyzed.
**Improve access to good quality maternal health services.** Health services should be located as close as possible to where women live, and must offer affordable, high-quality services. In order to meet required standards, health systems should have the following: an adequate number of trained staff; a regular supply of drugs, equipment, and supplies; and functioning referral systems. Services should also be respectful of, and responsive to, women’s needs, preferences, and cultural beliefs.

**Recognize that every pregnancy faces risks.** Because there is no reliable way to predict when women will develop complications, it is essential that all pregnant women have access to high-quality obstetric care throughout their pregnancies, especially during and immediately after childbirth. Antenatal care should not spend scarce resources on screening mechanisms that attempt to predict a woman’s risk of developing complications.

### References & Resources


### Web Resources

Maternal and Neonatal Health Program Resources: www.mnh.jhpiego.org/resources

Mothercare Project: http://www.mothercare.jsi.com/

Reproductive Health Outlook: http://www.rho.org/

Safe Motherhood: http://www.safemotherhood.org/

White Ribbon Alliance: http://www.geocities.com/white_ribbonalliance/

World Health Organization: http://www.who.int/