3. Maternal Mortality as a Human Rights and Gender Issue

The following are the key health statistics on women’s pregnancy-related mortality and morbidity around the world:

♦ An estimated 585,000 women die each year from pregnancy-related causes. For every woman who dies, approximately 10 others suffer a debilitating injury, often with life-long consequences.
♦ Maternal morbidity ratios in developing countries are 10-100 times those in developed countries. The maternal mortality ratio in developing countries is 100-1000 per 100,000 live births. In the United States, by comparison, the maternal mortality ratio is 8-12 per 100,000 live births.
♦ There are a half-billion women of reproductive age today, and maternal mortality is the leading cause of premature death among women of reproductive age.

Causes of Maternal Mortality

Causes of maternal deaths and illness have not changed dramatically in recent years. Figure 3-1 lists the major causes of maternal mortality.

Hemorrhage is the leading cause of maternal mortality in many settings, estimated to account for about one-fourth of all deaths. There is a high incidence of maternal mortality during and immediately after deliveries that take place at home. This is especially true in rural communities where a delivery is more often (than in urban areas) attended by a traditional birth attendant (TBA), by a relative, or perhaps by no one at all.

Among those who survive these and other complications of pregnancy, Figure 3-2 (on the next page) lists the most debilitating problems.

In terms of morbidity, there are limited data about the social, economic and emotional impact of the morbidities listed in Figure 3-2. We know that VVF and RVF are devastating conditions that leave women with little or no ability to control leaking urine and feces. Thousands of women in Africa are in need of a surgical repair for these conditions, which render them

<table>
<thead>
<tr>
<th>Causes of Maternal Mortality</th>
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<tr>
<td>Postpartum hemorrhage</td>
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<tr>
<td>Obstructed labor/Ruptured uterus</td>
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<tr>
<td>Toxemia/eclampsia</td>
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<tr>
<td>Postpartum sepsis</td>
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<tr>
<td>Abortion complications</td>
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<tr>
<td>Infectious diseases: malaria, AIDS, tuberculosis</td>
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Figure 3-1
isolated and outcast until the complications are repaired. Waiting lists are extraordinarily long in the small number of facilities that provide them surgical services.

### Maternal Mortality: The Three Delays

Maternal mortality is associated with delays in three areas that if addressed could make a major difference:

- **Delays in recognizing complications.** The seriousness of complications is not recognized or is recognized too late to seek or reach help.
- **Delays in transporting women to a facility.** Transportation has not been arranged in advance, money for transport has not been set aside, and finding and arranging transport leads to arrival too late for the woman to receive life-saving treatment.
- **Delays in receiving care at the facility.** Once the facility has been reached, treatment may be delayed by bureaucratic procedures; discriminatory treatment (especially of post-abortion patients); lack of available trained personnel; or lack of appropriate drugs, blood and supplies.

### Maternal Mortality Management

Reducing delays and increasing the availability of appropriate emergency obstetrical care (EOC) can greatly reduce maternal deaths. There are a number of important first steps at the community level, consisting of:

- **Family planning services.** All women should have access to good-quality family planning services and methods of their choice. Family planning reduces maternal deaths by reducing the number of women exposed through unwanted pregnancies and unsafe abortions.

- **Health education.** Community outreach to inform pregnant women, newlyweds, and family members (including husbands and mothers-in-law) about the risks of pregnancy, and the signs and symptoms of emergency obstetrical complications, can help reduce delay in seeking medical attention.

- **Training of village workers and TBAs.** Since many births are delivered by informally trained, non-licensed traditional birth attendants, it would save lives if TBAs have and use “clean birth kits” to reduce risk of infection, can recognize and refer for complications and can administer drugs, if feasible. It is essential, however, that referral emergency obstetrical services be available prior to major expenditures on further TBA training.
Arranging for and providing emergency transport. Awareness-raising within the community about the risks of pregnancy and how to respond to emergencies can lead to such practices as community-designated transportation and a fund to pay for it.

**Emergency Obstetrical Care**

The main life-saving interventions known as emergency obstetrical care are:

1. Management of hemorrhage (e.g., intravenous fluids and transfusions, and surgical intervention)
2. Antibiotics administered by injection or intravenous infusion
3. Ability to perform safe Cesarean sections
4. Management of abortion complications

Some of the above elements can be administered at a primary health care facility. Cesarean section and management of serious complications of abortion require care at a more medically sophisticated facility. In many parts of the developing world, there are no personnel trained to perform Cesarean sections. General physicians as well as health personnel other than physicians can provide these services if carefully trained.

An estimated 40-50 million abortions occur each per year. Of these, approximately 60,000-110,000 deaths occur due to unsafe abortion, representing about 13 percent of all maternal deaths (and as high as 20 percent in some settings). Most deaths occur to women who do not seek treatment for complications following abortion or delay too long in seeking treatment. While even women who reach the hospital with complications of unsafe abortion may die, treating such complications consumes the largest share of the obstetrical budget of many hospitals. Addressing the intractable contribution of unsafe abortion to maternal mortality and morbidity, particularly in those countries in which it is illegal, is greatly complicated by the highly controversial nature of abortion in society today.

**Other Important Issues in Addressing Maternal Mortality**

There are several other issues to consider in addressing maternal mortality, some of which may be surprising:

- **Training and roles for TBAs.** What level of care can TBAs deliver? How much emphasis should be put on training TBAs to recognize and treat complications as opposed to investing in other aspects of the health care system? While much effort has been devoted in the last 30 years to training TBAs to perform safe deliveries, the unpredictability of complications and shortage of facilities to treat them has meant that this effort has had minimal, if any, impact on
risk screening is not the way to go. Although prenatal care is important, it is not possible to predict accurately which women will suffer serious obstetrical complications. In fact, simply because of the large number of women classified as being at low risk, a majority of the complications leading to death are seen among low-risk women. Therefore, since most complications cannot be predicted or prevented, it is necessary to provide services universally for women who have complications.

Morbidity vs. mortality. For each maternal death, the number of women who are disabled, often permanently, is estimated at as much as ten times higher. Since the physical processes leading to mortality and morbidity are the same, approaches to decrease mortality will also help to reduce morbidity.

Measurement of maternal mortality. It is difficult to measure accurately the number of maternal deaths. Vital statistics in most poor countries are inadequate, and deaths may be attributed to other, non-pregnancy-related causes or go unreported altogether. Reporting is especially problematic for deaths occurring among unmarried women or due to unsafe abortion. On the other hand, if measurement has improved somewhat due to increased attention to the issue, deaths due to maternal causes will appear to be higher relative to the past, leading to an artificial plateau in death rates, despite a decade of efforts to promote safe motherhood.

Highlights of the Safe Motherhood Initiative

Initiatives to achieve safe motherhood have been underway for more than a decade. Nearly 20 years ago, new studies documented the extent of the problem of maternal mortality. In 1985 the World Health Organization sponsored a conference on maternal mortality. Referring to maternal and child health (MCH) services in developing countries, the question “Where is the M in MCH?” became an impetus for the development of the Safe Motherhood Initiative in 1987. A decade-long effort to reduce maternal mortality culminated in the 1997 Safe Motherhood conference in Sri Lanka. While much progress had been made in understanding the root causes of maternal mortality, experts noted that little progress had been made in reducing it.

The Averting Maternal Death and Disability Project

On this premise, the Averting Maternal Death and Disability (AMDD) Project of Columbia University’s Mailman School of Public Health was initiated.
in 1999, with a sizeable five-year grant from the Bill and Melinda Gates Foundation. The goal of AMDD is to assure that all women have access to emergency obstetrical services. To augment its small staff, experts from collaborating organizations serve as consultants. In addition, AMDD works through partner agencies, including affiliates of UNICEF, UNFPA, WHO, the World Bank, CARE, Save the Children, and the Regional Prevention of Maternal Mortality Program (RPMM) in Africa. AMDD collaborators are PATH, FHI, JHPIEGO, EngenderHealth and The Population Council. AMDD is working to provide EOC in India, Bangladesh, Pakistan, Nepal, Bhutan, Peru, Morocco and Mozambique. A number of African countries are involved through an alliance with RPMM.

### Maternal Mortality—A Human Rights Approach

High rates of maternal mortality—avoidable death in pregnancy and childbirth—constitute a violation of human rights and demand prompt attention and action. The technical solutions to reduce maternal mortality are not enough. As a basic human right, women should be able to have a child safely and with good quality of care. The human rights “system”—laws, policies, and conventions—must be used to hold states accountable for obligations undertaken pursuant to treaties. Human rights principles should be used to reshape health policies and programs and to guide the delivery of health services.

A human rights approach enforces the concept that the provision of appropriate health services is a right that people are entitled to demand from their government and a duty that a government owes its people. Presently there are two international treaties most relevant to the reduction of maternal mortality: The International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination Against Women.

A human rights approach addresses specific issues such as:

- Maternal mortality in the context of the complex social, economic and cultural conditions that keep it high
- Discrimination against women and against the poor and minorities
- Gross inequality between developed and developing countries

### Human Rights in the Context of the Three Delays

The Three Delays result from the human rights violations, especially the undervalued position of women in society:

1. Discrimination against women in the home and family prevents women from seeking and receiving health information and care.
2. Discrimination in access to health services on the basis of gender, class or
residence puts care out of reach for many women due to geographic and/or economic reasons. Adequate care is especially lacking in rural areas.

3. Discrimination against women in provider-patient relationships as well as the macroeconomic forces currently devastating health systems contribute to the likelihood that decent care will be non-existent or fatally delayed at the facility level.

We must acknowledge that we are not opening new territories. For example, UNICEF is committed to the human rights approach and is poised to use “rights-based” programming. However the challenge is to put human rights principles and health programming together. In order to reduce maternal mortality, health programs must perform adequate emergency obstetrical care. Without investments in programs, human rights principles remain unenforceable.

How Can Progress in Reducing Maternal Mortality Be Assessed?

In 1997, WHO, UNICEF and UNFPA issued *Guidelines for Monitoring of the Availability and Use of Obstetric Services*. The guidelines are a tool for documenting, monitoring and advocating for EOC at the local, national and international levels. They provide program managers and policymakers with indicators and minimum acceptable standards to help them monitor progress in increasing access to and use of EOC services. The UN Guidelines assess the EOC environment by asking these basic questions:

♦ Are enough health facilities providing EOC?
♦ Are the facilities equitably distributed across the population?
♦ Are pregnant women in general and those with obstetric complications using the facilities?
♦ Are the facilities providing enough life-saving services to meet needs?
♦ Is the quality of these services adequate?

The *Guidelines* offer an alternative to maternal mortality rates and ratios in terms of measuring progress in reducing maternal deaths. They are less expensive to use, can show changes in a relatively short period of time, and can be used to monitor compliance with international human rights laws to end discrimination against women. Actual measurement of maternal mortality ratios in poor countries is grossly underreported and the costs of “fixing” the vital registration system is far too high, given the importance of using limited funds to provide emergency services.

As a postscript, one could note that the human rights approach is relevant in developed countries too: in the United States the lack of health insurance for many pregnant women and others is equally a violation of human rights.