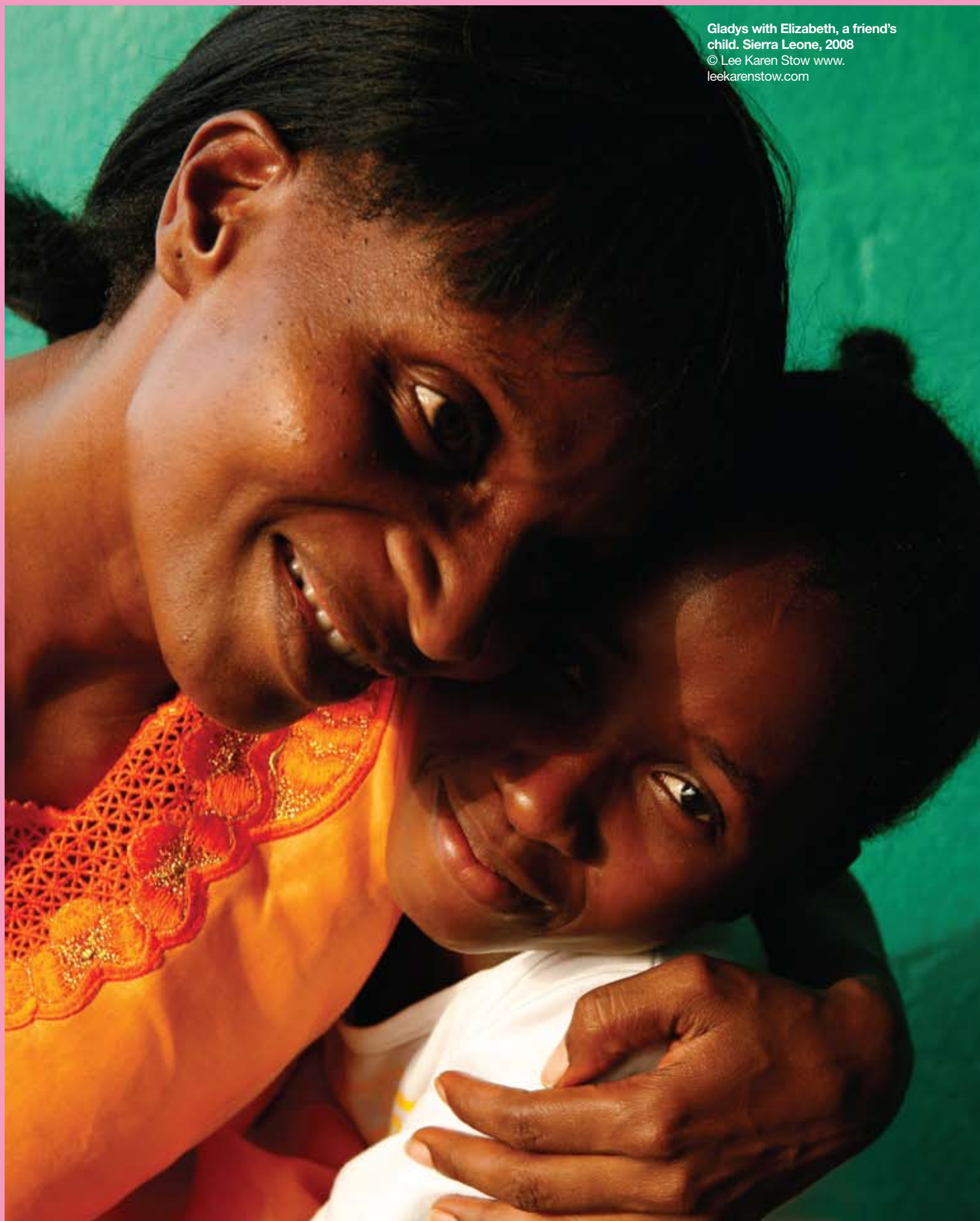
BRIEFING

MATERNAL HEALTH IS A HUMAN RIGHT

Amnesty International

‘Women are not dying of diseases we can’t treat. ... They are dying because societies have yet to make the decision that their lives are worth saving.’

Mahmoud Fathalla, former president of the International Federation of Obstetricians and Gynaecologists



Gladys with Elizabeth, a friend’s child. Sierra Leone, 2008

‘Preventable maternal mortality and morbidity is a violation of women’s rights to life, health, equality and non-discrimination. The time has come to treat this issue as a human rights violation, no less than torture, “disappearances,” arbitrary detention and prisoners of conscience.’

Mary Robinson, former UN Commissioner for Human Rights

MATERNAL HEALTH IS A HUMAN RIGHT

Each year millions of women face death, serious illness and permanent disability because of complications relating to pregnancy and birth. At its root, it is inequality and discrimination that lead to half a million women – one women every minute – dying due to pregnancy, childbirth or complications. Most maternal deaths are preventable if basic information and healthcare are available to women, and therefore many of the deaths amount to violations of a woman’s right to life, health, non-discrimination and equality.

PREVENTABLE CAUSES

Of the estimated 536,000 maternal deaths worldwide in 2005, 99 per cent were in developing countries and more than half were in sub-Saharan Africa. Together, South Asia and sub-Saharan Africa accounted for 86 per cent of all maternal deaths. Fourteen countries had a maternal mortality ratio of at least 1,000 per 100,000 births; 13 of these were in sub-Saharan Africa and the 14th was Afghanistan. At the other end of the spectrum, 30 countries – most of them in Europe – had a maternal mortality ratio of less than 10 per 100,000 (see table overleaf). The global disparity shows that high maternal mortality can be avoided, given adequate resources and political will.

The medical causes of maternal deaths are known: the main causes are severe bleeding, infections, eclampsia (a type of seizure during pregnancy) and other hypertensive disorders, obstructed labour and unsafe abortion. Although unpredictable, they are all treatable. Research shows that an estimated 74 per cent of maternal deaths could be averted if all women had access to services for preventing or treating pregnancy and birth related complications – in particular to emergency obstetric care (medical intervention), family planning services, ante-natal and post-natal care (before and after birth).

The world’s governments have recognised the problem, and reducing maternal mortality (maternal deaths) is one of the UN Millennium Development Goals (MDGs) – a set of internationally agreed targets to reduce poverty. Millennium Development Goal 5 seeks to cut maternal mortality by 75 per cent from its 1990 levels by 2015. But of all the MDGs, this is the one where least progress has been made.

A PREVENTABLE DEATH

Adama Kamara was 25 when she died in the village of Kapairo, Kambia district, in Sierra Leone. On 24 December 2008, about six months into her pregnancy, Adama went into premature labour. After a day of hoping she would get better, her husband borrowed from his neighbours to pay Le40,000 (£7) for a car to take her to hospital.

At the hospital he paid Le2,000 (about 35p) for registration and Le10,000 (£1.75) for a hospital bed, in addition to charges for medicines.

Adama spent that day and the next in the hospital, but no doctor was present. Pa Abu Kamara went home on the second day. When he returned to the hospital several hours later, he found that Adama had delivered the baby, but it had died. Adama was bleeding heavily. Although it was an emergency and the government has a free care policy, there was no free medication. Pa Abu Kamara told Amnesty International, ‘I didn’t have any more money. I just took Adama out of the hospital and took her home. She did not look good and also I did not want to pay the hospital charge for her body which is at least Le60,000 [£10.55].’ Adama was delirious by this point and unable to speak for herself. She died at home the next day.

MM = MATERNAL MORTALITY PER 100,000 LIVE BIRTHS
SA = PERCENTAGE OF BIRTHS WITH SKILLED ATTENDANT

MATERNAL DEATHS BOTTOM 14 (alphabetical order)

COUNTRY	MM	SA
Afghanistan	1800	14%
Angola	1400	47%
Burundi	1100	34%
Cameroon	1000	63%
Chad	1500	14%
DR Congo	1100	74%
Guinea Bissau	1100	39%

COUNTRY	MM	SA
Liberia	1200	46%
Malawi	1100	54%
Niger	1800	18%
Nigeria	1100	35%
Rwanda	1300	52%
Sierra Leone	2100	42%
Somalia	1400	33%

Sources: Maternal Mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. The State of the World's Popluation 2009, UNFPA

DISCRIMINATION AND INEQUALITY

The preventable deaths of more than half a million women each year are the ultimate outcome of systematic and pervasive discrimination against women and girls throughout their lives. Those most likely to die in pregnancy or childbirth are the poorest, the youngest and the least educated.

In circumstances where women have low status and lack economic independence, they may not be free to decide for themselves to go to a health facility, whether for family planning, pregnancy (antenatal) care, deliveries or emergency care. The decision is usually in the hands of the husband, and may be based on whether there is sufficient money to pay for transport or treatment. Because of women's low status, their need for health care may receive low priority when decisions are made about the allocation of scarce resources within the family.

Discriminatory laws, traditional practices and beliefs can greatly increase the risks to women during pregnancy and childbirth by reinforcing the low status of women in society and devolving decision-making to male relatives.

This deep-rooted discrimination undermines women's human rights including their right to health. In 2005, The UN Committee on the Elimination of all forms of Discrimination Against Women expressed concern about Burkina Faso for 'the continuing strong prevalence of patriarchal attitudes and deep-rooted stereotypes and of customs and traditions that discriminate against women, particularly women in rural areas, and constitute violations of their human rights'. In its report to the committee, the government of Burkina Faso acknowledged 'the persistence of certain traditional and religious practices that put women at a disadvantage, including the *levirate* (the practice of marrying a widow to her deceased husband's brother), under age and/or forced marriage, excision (female genital mutilation) and the reluctance to send girls to school'.

Education for women and girls, and access to information on sexual and reproductive health, directly affects their decisions about pregnancy and childbirth. Girls who have been educated are likely to know more about health care and nutrition, to make greater use of health services during pregnancy and birth, and to increase the spacing between pregnancies – thus reducing their risk

INEQUALITY OF POWER

'After seven pregnancies and five children, I told my husband that I wanted to use contraceptive methods but my husband refused and told me that if I did this, I should return to my mother's home. I therefore had to obey him'

A woman in Ouagadougou, Burkina Faso

- A study by CARE in Sierra Leone found that 68 per cent of mothers said that the decision on where to deliver a child was usually made by the husband at the onset of labour.
- In Burkina Faso, opposition to contraception is often rooted in the traditional roles assigned to women and the value placed on children as a source of wealth. The cost of contraception means women without independent sources of income find it very difficult to choose when to have a child.
- In Sierra Leone, it is widely believed in rural areas that obstructed labour is caused by a woman's infidelity. Often, time and energy are wasted in trying to obtain a confession instead of ensuring that the woman has access to emergency obstetric care.

TOP 14 (alphabetical order)

COUNTRY	MM	SA
Austria	4	100%
Australia	4	99%
Bosnia / Herzegovina	3	100%
Czech Rep	4	100%
Denmark	3	N/A
Germany	4	100%
Greece	3	N/A

COUNTRY	MM	SA
Iceland	4	N/A
Ireland	1	100%
Israel	4	N/A
Italy	3	99%
Kuwait	4	100%
Spain	4	N/A
Sweden	3	N/A

UK (ranking 25th) **US** (ranking 34th)

COUNTRY	MM	SA
UK	8	99%
US	11	99%

of maternal death. Educating girls for six years or more produces a drastic and consistent improvement in their care before, during and after childbirth, according to UNICEF. For each additional year of education achieved by 1,000 women, two maternal deaths will be prevented.

Violence against women and girls restricts their ability to refuse sex or insist on using contraception, as well as increasing the risk to their health and lives during pregnancy. For example, adolescent pregnancy and motherhood are a foreseeable consequence of early marriage and entail greater risks for the mother, who may not have reached physical maturity. Maternal mortality ratios for girls who give birth between the ages of 15 to 19 are twice as high, and for girls aged 10 to 14 four times as high, as for women in their 20s. Pregnancy-related deaths are the leading cause of mortality for 15-19 year old girls worldwide.

Women who face multiple forms of discrimination as a result of gender, race, ethnic minority, language, disability or other identity based discrimination also suffer from increased maternal mortality risks.

MULTIPLE DISCRIMINATION

'How can you live in oppression and get second-rate care and not have it reflected in outcomes?… Black women will be more likely to die until we are treated equally.'

Shafia Monroe, President of the International Center for Traditional Childbirth, Portland, Oregon, USA

- In the USA, African-American women are nearly four times more likely to die of pregnancy-related complications than white women and these disparities have not improved in more than 20 years
- In Peru, Indigenous peoples are disproportionately represented among the rural poor and face ethnic discrimination. In rural areas, 74 per cent of women give birth in their homes, while 90 per cent of women in Indigenous communities do so.

EMERGENCY OBSTETRIC CARE

Discrimination and poverty also restrict women's access to life-saving medical care. Roughly 15 per cent of live births have complications such as haemorrhage (bleeding), sepsis (blood infection) and obstructed labour which require

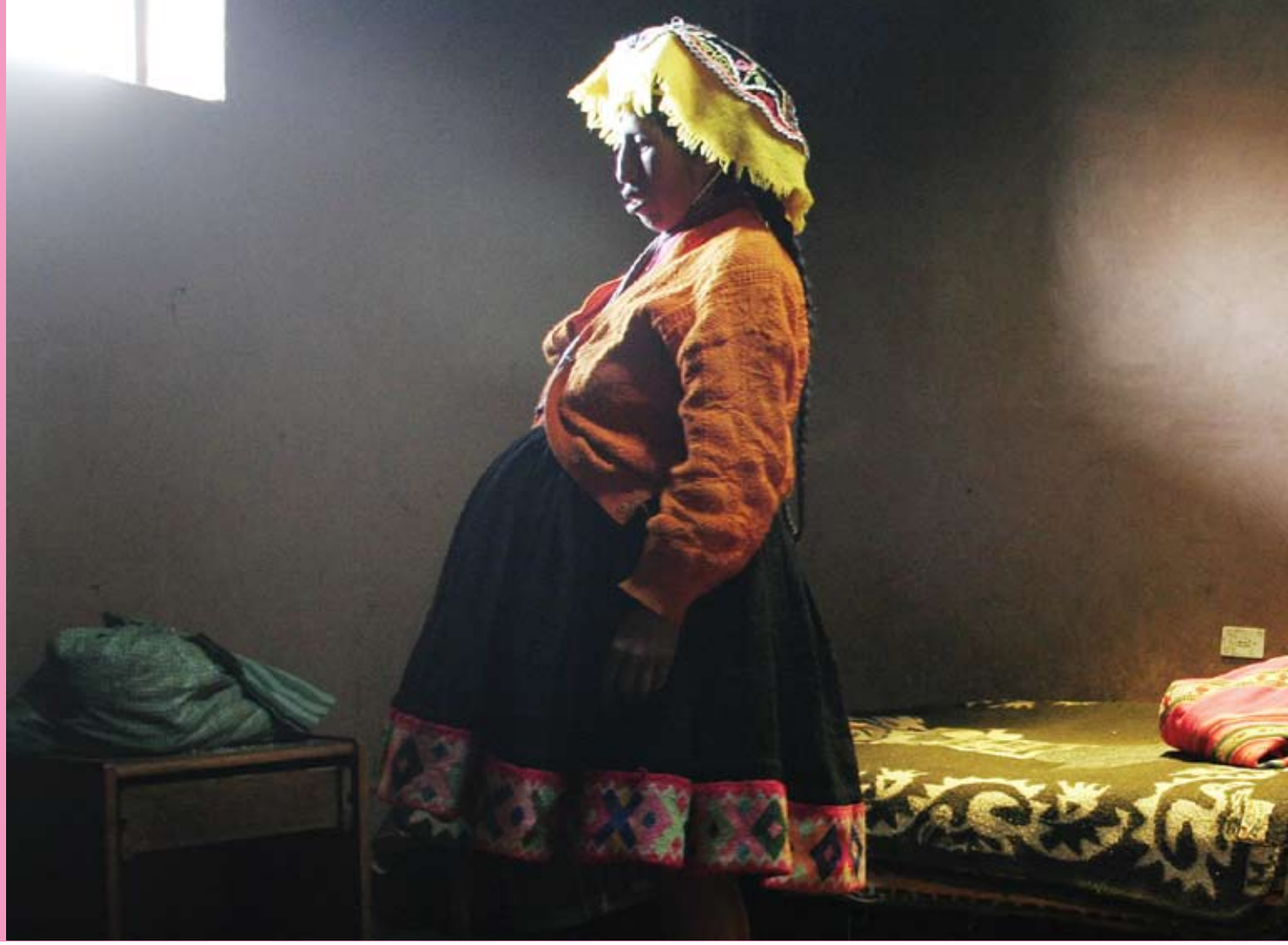
DEFINITIONS

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Maternal mortality 'The death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.' (World Health Organisation)

Maternal mortality ratio The risk associated with each pregnancy, usually given as the number of maternal deaths per 100,000 live births.
Note: *Measuring maternal mortality accurately is possible only where all deaths and their causes are accurately registered. Elsewhere, census, surveys or models have to be used to estimate levels of maternal mortality.*

Unsafe abortion is the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or in a place that does not meet minimal medical standards, or both.



‘I think she died because we did not have money and therefore did not go to the hospital on time. We took her to the traditional birth attendant to deliver because her husband did not have any money to take her to the hospital.’

Sarah Kabbia describes the delays in getting her sister to hospital in Sierra Leone

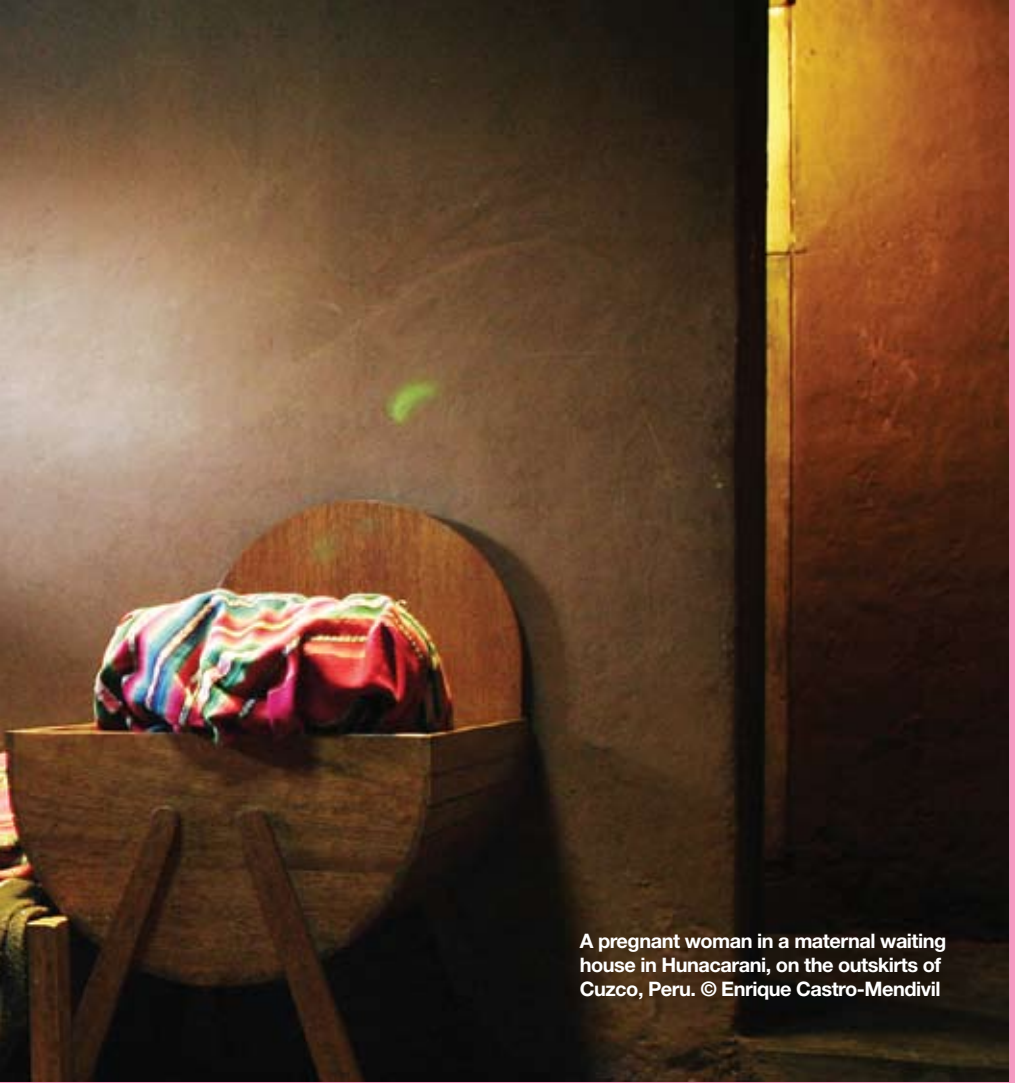
emergency obstetric care. When such complications arise, women need timely treatment in a clinic or hospital – but they do not always get it. Worldwide, four out of 10 births take place without a skilled birth attendant.

In many countries, a disproportionate share of health resources is targeted at the urban, affluent and powerful sectors of society. The result is that the overwhelming majority of women who die from pregnancy-related causes are from poor and marginalised communities. The skewed distribution of services is compounded by inadequate, unreliable and costly transport infrastructure. Often women from rural areas must travel long distances to the health facility, and transport is often unreliable and expensive. Many do not make it in time.

In many parts of the world, cost of treatment is a barrier. Many women refrain from seeking health care because they know or fear that the cost will be more than they can afford. Many governments have good policies such as subsidies for emergency obstetric care or exemption from fees. However, exemptions and waivers have often been found to be unreliable, ineffective, costly, difficult to administer and open to abuse. Unless the public knows that the exemptions exist and who can claim them, women may still delay asking for health care and any unscrupulous health workers may continue to charge fees and pocket the proceeds.

Even where women can gain admission to a hospital or clinic in time, their health and survival depend on the quality of care they receive. Generally, health care systems that fail to provide adequate health care have several recurrent problems: inadequate health infrastructure; poor working conditions; lack of trained personnel; lack of skilled birth attendants; inadequate provision of emergency obstetric care; blood shortages; delays in referral decisions and shortages of drugs and medical equipment.

In many places, maternal health information is not available in local languages, or the languages of ethnic minorities, and health personnel may be unable or unwilling to speak local or minority languages. If women cannot explain to health care staff the pain or symptoms they are suffering, their diagnosis will be less accurate. And



A pregnant woman in a maternal waiting house in Hunacarani, on the outskirts of Cuzco, Peru. © Enrique Castro-Mendivil

INEQUALITY

Worldwide, births in urban areas are twice as likely to be attended by skilled health personnel as births in rural areas.

In Peru, women in rural areas are twice as likely as those in urban areas to die from causes related to pregnancy.

In Chad, only 1 per cent of the poorest women are attended by skilled health personnel during delivery, compared with 48 per cent of the wealthiest women.

In the USA, national per capita health expenditure for the average person in 2003 was $5,775; for the Indian Health Service, which runs health facilities for Native American and Alaska Native peoples, it was $1,900.

discriminatory attitudes to women who do not speak the majority language can make matters worse.

Another important barrier, particularly for rural and Indigenous women, is that health care is not provided in a way that is acceptable to them. They feel uncomfortable or unsafe using the services provided and so prefer not to use them. The result is that many women choose the real and known risk – giving birth in the community – over the unknown risk – being treated in a frightening and alien environment.

In Peru, for example, few health workers speak Indigenous languages. And medical training centres ignore Indigenous women's cultural preferences and traditional birthing techniques. One doctor told Amnesty: 'The patients give birth almost crouching. The husband holds them up. I am nearly kneeling with my hands underneath the skirt … Vertical birthing is an ancestral tradition. It is faster and easier for women … It would be really good if there was training on vertical birthing.'

BAN ON SAFE ABORTION

In some countries, women are denied access to essential treatment by law, policy or practice. Where severe restrictions are placed on safe abortion, the risk of women seeking unsafe abortions is increased. Criminalisation and denial of access to abortions where the woman's life is threatened is felt acutely by the most vulnerable women in societies: rape and incest victims; women living in poverty; young women and girls; and women affected by crises and armed conflict. Complications resulting from unsafe abortions account for nearly 70,000 maternal deaths each year – 13 per cent of the total. In Africa, a quarter of all those who have an unsafe abortion are adolescent girls.

In a few countries, mostly in Latin America, abortions are denied even where continued pregnancy risks the life or health of the women or girl or when pregnancy is a result of rape or incest. Whatever the circumstances or risks, girls and women are compelled to carry pregnancies to term, even young girls who are physically unable to carry a pregnancy to term and even when the foetus has severe abnormalities and no prospect of survival.

For example, the revised penal code of Nicaragua criminalises all abortions, endangering the life and health of girls and women and putting health professionals in legal jeopardy. In some instances doctors, fearful of being accused of carrying out an abortion, have delayed intervening even when a miscarriage is already well under way. Some have refused to treat women with ectopic (where the foetus is growing outside the womb) pregnancies – which cannot be carried to term – for fear of prosecution. In one recent case, a pregnant woman was denied treatment for cancer because she was pregnant.

FAMILY PLANNING

Pregnancies spaced less than 15 months apart more than double the risk of the mother dying. A woman who has been pregnant six times has twice the risk of dying a maternal death as a woman who has been pregnant only three times. So a woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy. This ability depends on the availability of family planning information and services.

At the individual level, family planning can reduce the number of times a woman becomes pregnant. Access

A HUMAN RIGHTS ISSUE

In June 2009 the **UN Human Rights Council** passed a resolution (co-sponsored by more than 70 UN member states) acknowledging that preventable maternal mortality and morbidity is a human rights issue and calling for national and international efforts to protect women worldwide to be scaled up. By signing on to the resolution, 'governments recognise that the elimination of maternal mortality and morbidity requires the effective promotion and protection of women and girls' human rights, including their rights to life; to be equal in dignity; to education; to be free to seek, receive, and impart information; to enjoy the benefits of scientific progress; to freedom from discrimination; and to enjoy the highest attainable standard of physical and mental health including sexual and reproductive health'.

to family planning services also reduces the number of unintended and unwanted pregnancies, and thus the number of deaths resulting from unsafe abortion. It also enables young girls to delay their first pregnancy until they are old enough to give birth safely.

The World Bank estimates that access to voluntary family planning could reduce maternal deaths by 25 to 40 per cent, and child deaths by as much as 20 per cent. However, in many countries funding for family planning has been curtailed and supplies of contraceptives are inadequate. Financial support for population and reproductive health programmes declined as a percentage of overall global health aid, from about 30 per cent in 1994 to 12 per cent in 2008.

MATERNAL HEALTH AND HUMAN RIGHTS

When women die unnecessarily in pregnancy or through childbirth, it is a violation of their right to life. It signals a failure of governments to act with due diligence, that is with due care and effort, to respect, protect and fulfil women's human rights.

Sexual and reproductive health services are critical for women to enjoy their right to physical and mental integrity, their right to health and their right to determine the number and spacing of their children. States have a responsibility to take appropriate measures to ensure that women can access the services they need to enjoy these rights.

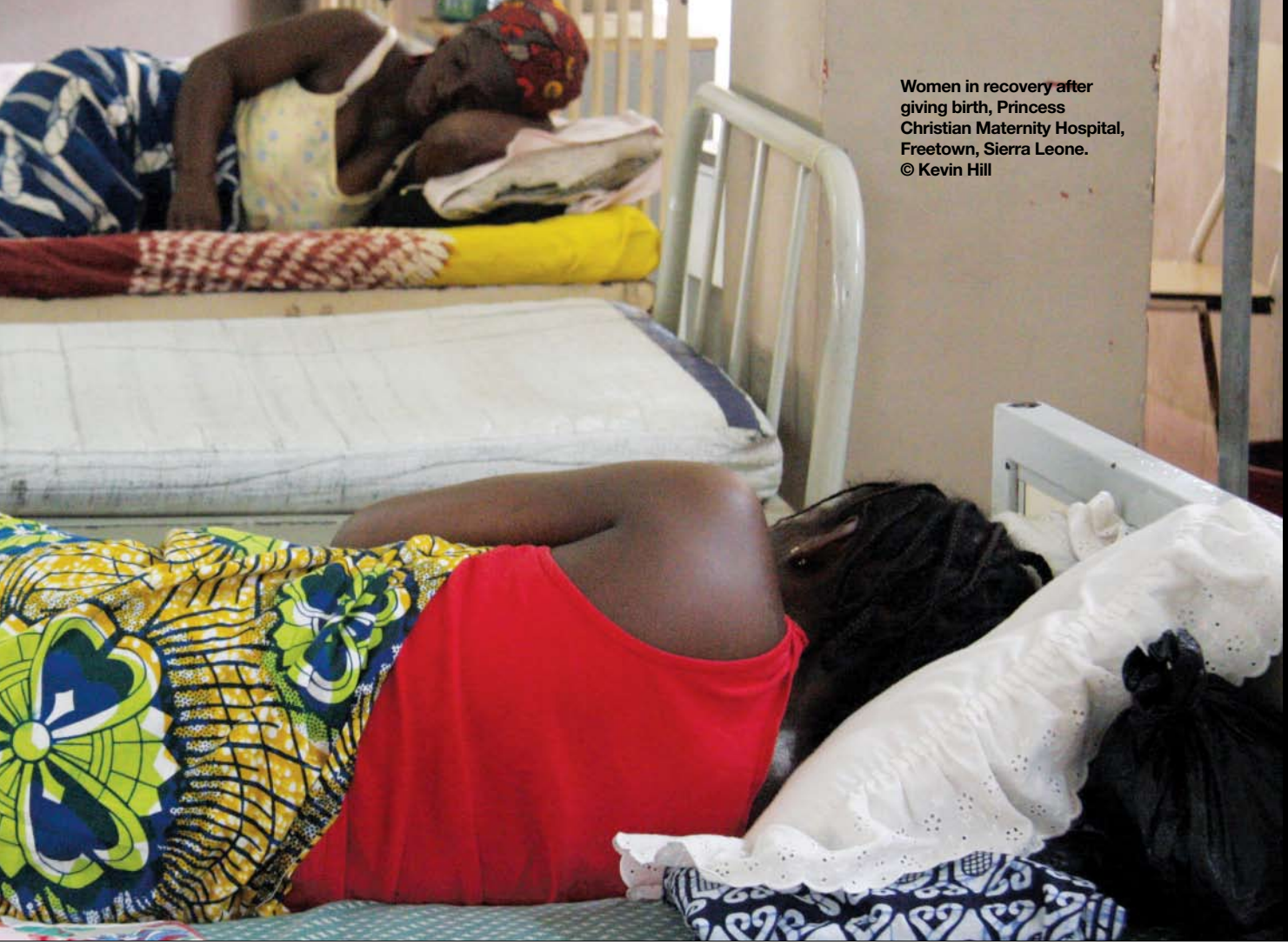
States have international obligations to uphold women's rights to life and health, and certain human rights conventions and other international agreements explicitly oblige states to reduce maternal mortality ratios, and to ensure that family planning services are available.

Article 12 of the **International Covenant on Economic, Social and Cultural Rights** (ICESCR) obliges states to 'recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and to take steps to provide for 'the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child'.

The UN Committee on Economic, Social and Cultural Rights, which is responsible for monitoring the treaty, says this must be 'understood as requiring 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.' (General Comment 14. para 14).

The **Convention on the Elimination of All Forms of Discrimination Against Women** (CEDAW), in Article 12, requires states to 'ensure, on a basis of equality of men and women, access to health care services, including those related to family planning' and to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation'.

CEDAW Article 16 (1)(e) says that women have the right to 'decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise



Women in recovery after giving birth, Princess Christian Maternity Hospital, Freetown, Sierra Leone. © Kevin Hill

these rights'.

General Recommendation 24 of the CEDAW committee notes that high maternal mortality rates and lack of access to contraception, among other things, are potential breaches of a state's duty to ensure women's access to health care.

TACKLING THE PROBLEM

Securing women's human rights is essential to addressing maternal deaths. This includes ending violence against women, addressing their low social status and ensuring their right to education, as well as respecting, protecting and fulfilling sexual and reproductive rights.

Another key element is the right to participation and consultation of women in the planning of maternal health care. Without genuine participation of women from the communities who will use maternal health services, those services will not adequately reflect women's needs and choices. Reluctance to use health centres because of cultural (or other) insensitivity is a major barrier to reducing maternal deaths.

Governments and international organisations have known for years that the vast majority of maternal deaths worldwide are preventable, and have acknowledged the scale of the problem. They have recognised the importance of ensuring that women receive appropriate care during pregnancy and delivery. Around the world, medical professionals, women's groups and development agencies are working to improve maternal health and to put pressure on governments to act.

INTERNATIONAL INITIATIVES

Among the most important international initiatives to combat maternal deaths are the UN International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs).

The ICPD, which took place in Cairo in 1994, adopted a 20-year Programme of Action which focused on individuals' needs and rights, rather than on demographic targets. The programme includes goals for education – especially for girls – and for the reduction of infant, child and maternal mortality rates.

The Millennium Development Goals, outlined in the Millennium Declaration of 2000, are a set of time-bound targets for reducing poverty worldwide. They were agreed by all the world's countries, and all the leading development institutions. MDG 5 aims to improve maternal health, and specifically to reduce the maternal mortality ratio and achieve universal access to reproductive health. MDG 3, which aims to promote gender equality, is also relevant to maternal health. Its targets include eliminating gender disparity at all levels of education.

THE UK

Through the work of the Department for International Development, the UK government has been a strong support for maternal health programmes and has acted as a strong global advocate for measures to reduce maternal deaths.

Yeabu Mansaray and Nana Samura, vegetable growers. Sierra Leone, 2008
© Lee Karen Stow www.leekarenstow.com

AMNESTY INTERNATIONAL'S CAMPAIGN FOR MATERNAL HEALTH

The campaign to hold states responsible for reducing maternal deaths will build on our work from the Stop Violence Against Women campaign to uphold women's human rights including their right to life, their right to health, and their sexual and reproductive rights.

GLOBALLY, AMNESTY INTERNATIONAL IS CALLING FOR:

States to uphold their international obligations on gender equality and non-discrimination and to respect, protect and fufil women's human rights as critical to reducing maternal mortality. For example:

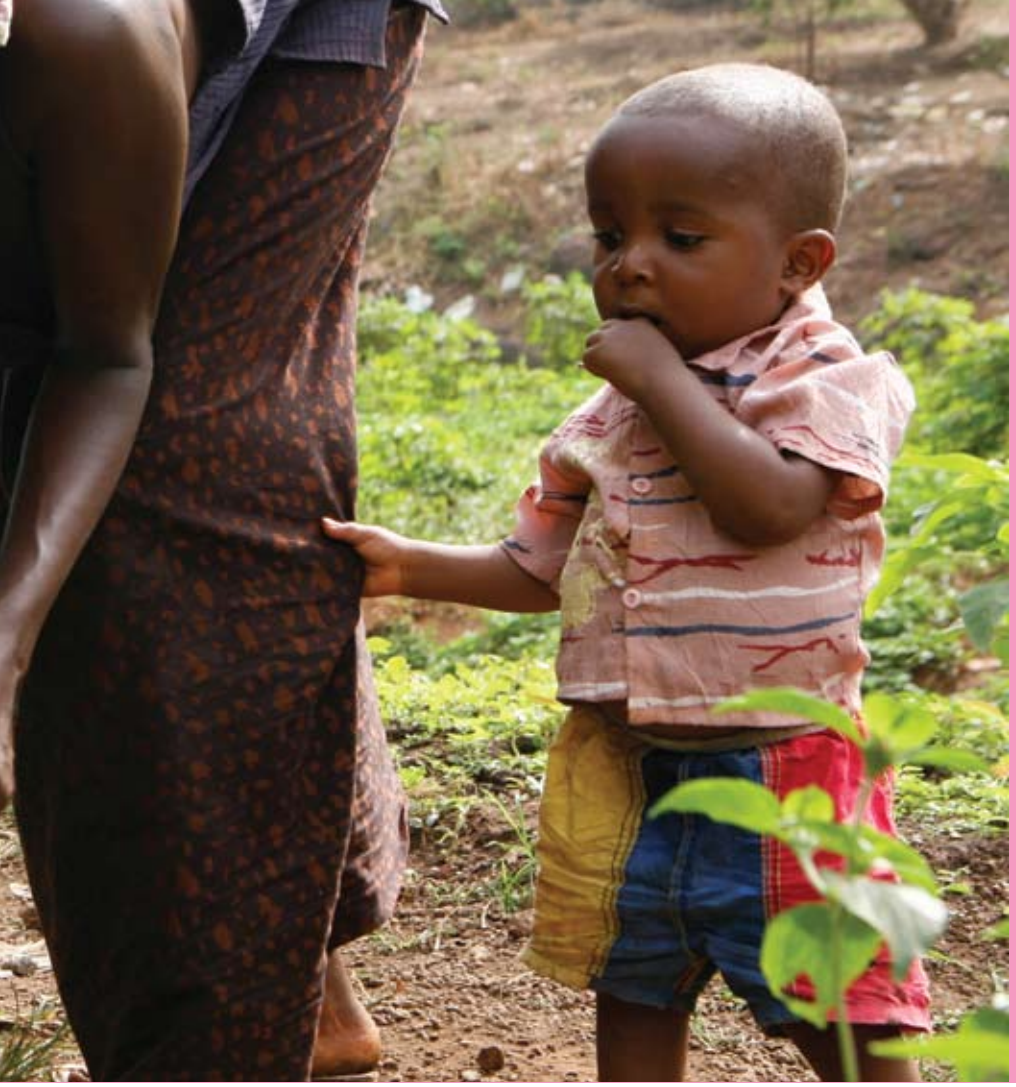
- governments to implement their CEDAW obligations to take all appropriate measures to end discrimination against women in all its forms, including the elimination of customary practices harmful to women, or which are based on stereotyped roles for men and women and reinforce the subordination of women;
- governments to implement CEDAW Article 12 recommendations to ensure appropriate services for pregnancy, including free services where necessary and adequate nutrition;
- all states to take measures to implement the Programme of Action from the UN International Conference on Population and Development (ICPD)

States to ensure access to information and services on sexual and reproductive health and rights. For example:

- expand and improve sexual and reproductive health information and services such as family planning services for all women including adolescents;
- decriminalise abortion and ensure access to therapeutic abortions to save women's lives and safeguard their health, and for victims of rape, sexual violence and incest;
- take all necessary measures to ensure that safe and legal abortion services are available, accessible, and of good quality for all women who need them in line with national legislation.

States to act with due diligence to ensure that all women have access to information, education and services essential for maternal health without discrimination. For example:

- meet CEDAW obligations to take all appropriate measures to remove discrimination against women in health care, including family planning;
- ensure that costs are not a barrier to use of essential health services, including emergency obstetric care and other reproductive health services;
- increase the availability and accessibility of essential health services, including emergency obstetric care and skilled attendants in childbirth.
- ensure Indigenous and rural women have access to culturally sensitive maternal health services.
- develop and implement human rights centred national action plans on maternal health, with the active participation of women.



UN MILLENNIUM DEVELOPMENT GOAL 5: IMPROVE MATERNAL HEALTH

REDUCE BY THREE QUARTERS, BETWEEN 1990 AND 2015, THE MATERNAL MORTALITY RATIO

Indicators:

- Ratio of maternal deaths to live births
- Proportion of births attended by skilled health personnel

ACHIEVE, BY 2015, UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

Indicators:

- Contraceptive use rate
- Adolescent birth rate
- Antenatal care coverage
- Unmet need for family planning

IN THE UK, AMNESTY INTERNATIONAL IS CALLING FOR:

- the government and political parties to maintain the UK's position as a global leader on ending maternal mortality and prioritise it as a matter of urgency;
- the government and political parties to push for maternal health to be prioritised in the global MDG review process;
- the government to take action to increase global commitments and recognition at international fora of MDG5 on maternal mortality and MDG3 on gender equality as essential to reducing maternal mortality;
- the government to advocate strongly at international fora for women's sexual and reproductive health and rights, including family planning and the principle of equality and non-discrimination in access to information and services;
- the government to maintain its position as a global leader and advocate on maternal health and to strengthen support for gender equality and women's human rights as key to delivering progress on MDGs 3 and 5.

Amnesty International UK supported the Manifesto for Motherhood – a joint NGO manifesto that details how the UK government can:

- support a global increase in financing for maternal, newborn and child health;
- place maternal, newborn and child health at the heart of health system strengthening;
- realise its international commitments on sexual and reproductive health and rights.

Amnesty will also be working on specific calls and recommendations for donor and recipient countries on the basis of our primary country research.

FIND OUT MORE

www.amnesty.org.uk/maternalhealth

AMNESTY REPORTS

Fatal flaws: Barriers to maternal health in Peru
Index: AMR 46/008/2009

The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalized
Index: AMR/43/001/2009

Out of reach: The cost of maternal health in Sierra Leone
Index: AFR 51/005/2009

Giving life, risking death: Maternal mortality in Burkina Faso
Index: AFR/60/001/2009

Deadly delivery: The maternal health care crisis in the USA
Index: AMR 51/007/2010

THE MILLENNIUM DEVELOPMENT GOALS

www.un.org/millenniumgoals

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

www.unfpa.org/icpd

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Cover photo: Rebecca Kamara with her first-born, Raymond. Sierra Leone, 2008