NO MORE
NEEDLESS DEATHS

A call to action on human rights and maternal mortality
Guide to abbreviations

CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women (UN General Assembly, 18 December 1979)

EmOC: Emergency obstetric care

GC 14: General Comment no. 14 on the Right to the Highest Attainable Standard of Health (UN Committee on Economic, Social and Cultural Rights, 4 July 2000)

ICCPR: International Covenant on Civil and Political Rights (UN General Assembly, 16 December 1966)

ICESCR: International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 16 December 1966)

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Cover photo: Alejandrina Condori Zamata, women’s leader and health community agent from Asillo Pampa Grande Community presenting her views in the workshop “Knowing our body, knowing our rights” in Azangaro Province, Puno, Peru. Photograph by Luz Estrada, Health Rights Program, CARE Peru.

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IIMMHR is the first civil society human rights effort aimed at reducing maternal mortality. For more information, visit www.righttomaternalhealth.org.
More than 500,000 women die every year from complications of pregnancy and childbirth. These tragic and preventable deaths are the culmination of human rights violations against women and girls in many aspects of their lives and at all levels of health decision-making. Ending these human rights violations is essential for preventing maternal death.

Women have the right not to die needlessly in the process of giving birth. Governments across the world have pledged both to reduce maternal mortality and to protect women from the human rights abuses that underlie these deaths. But the rate at which women die globally has changed little for many years.

More than 99% of maternal deaths occur in developing countries and low-income communities. Many health problems are more prevalent and severe among people living in poverty than among the better-off, but maternal death reflects this disparity most acutely. Women in wealthy countries face a maternal mortality risk of about 1 in more than 7,000, but 1 woman in 22 in Africa and 1 in 7 in the world’s poorest countries dies of complications of pregnancy or childbirth. These striking health statistics are the result of gross discrimination against and disempowerment of low-income women.

The immediate causes of about 80% of maternal deaths are five kinds of obstetric emergencies: infection, hemorrhage, hypertensive disorders (such as eclampsia), prolonged or obstructed labor, and complications of unsafe abortion. For every woman who dies from these conditions, about 30 women survive but are injured or permanently disabled. Proven health interventions can prevent these emergencies from resulting in death and disability, but to be effective, these services must be accessible, affordable, of good quality, and culturally appropriate. Underlying causes of maternal mortality go beyond obstetric emergencies to the many factors that
The number of annual [maternal] deaths has not changed in ... thirty years. You can bet that if there was something called paternal mortality, the numbers wouldn’t be frozen in time for three decades.

—Stephen Lewis, former UN Special Envoy on HIV/AIDS in Africa, April 26, 2005
lead to unwanted pregnancies and the many ways in which their subordination renders women unable to utilize health services, make health-related decisions on their own, or have their voices heard in the corridors of political power.

Some low-income countries have reduced maternal death by strategic investment in making skilled care accessible and available to the majority of women, including good-quality emergency obstetric care (EmOC), and by involving women and communities in making decisions about how health services are organized, managed, and provided. It is time to hold governments to their commitments to respect, protect, and fulfill the human rights of women and guarantee that women will not die while giving life. This call to action, which is endorsed by the steering committee of the International Initiative on Maternal Mortality and Human Rights, highlights human rights violations underlying maternal mortality and the actions needed to address those violations to make safe pregnancy the priority it must be.

That so many millions of women have died and will die for lack of good-quality maternal health care is a human rights scandal; these needless deaths must be stopped. Without concrete action in favor of women’s human rights, maternal injury and death will continue.

What follows are five reasons why ensuring women’s human rights is essential to eliminating preventable maternal death and injury.
Maternal death is not inevitable. Women have a right to lifesaving care.

The causes of maternal death and the most effective ways of preventing it have been understood for many years. For the rich and for women with good access to health services, maternal mortality has been effectively eliminated as a health problem. Public health questions surrounding best practices in reducing maternal mortality have been settled with a strong international consensus regarding steps that must be taken. Governments that fail to apply the resources at their disposal toward implementing these proven measures show disregard for women’s rights and humanity.

Women’s right to life should not be compromised by the fact of pregnancy. The right to non-discrimination includes the right to basic and emergency obstetric care. Governments’ failure to protect these rights often results from deep inequities in political power between men and women, between wealthy and poor, and between urban and rural. Allocating adequate public resources to maternal and reproductive health services is a concrete part of fulfilling their commitments to protect women’s rights.

Reducing maternal mortality is challenging for governments, especially in low-income countries. Maternal mortality is difficult to measure precisely, partly because some deaths occur at home rather than in hospitals or among women who die on their way to the hospital. But the difficulty of measuring maternal mortality is no excuse for inaction. Governments can move forward, relying on well-known evidence-based strategies and services to ensure access to the continuum of maternal health care as well as broader measures to protect women’s rights.

It has been widely recognized that all births should take place in the presence of a skilled birth attendant. In 2000, UN member states agreed at the Millennium Summit that skilled attendance at birth is a key indicator for measuring governments’ progress in addressing
maternal mortality. A skilled attendant is a doctor, nurse, or midwife who can manage normal deliveries and diagnose and refer emergencies to appropriate facilities. Moreover, protecting women’s right to avoid unwanted pregnancies must be a central element of reducing underlying risk of maternal death and injury (see point 4, below).

With respect to EmOC, the details have been laid out by the United Nations as a series of “process” indicators (see Box 1).

The UN-endorsed EmOC indicators have been applied by some low-income countries that have made progress in spite of poverty (see Box 2).

Minimum service standards for access to contraception, skilled attendance at birth, and EmOC are human rights obligations of governments because they are essential to protecting women’s

**Box 1**

**UNITED NATIONS EMOC INDICATORS TO PREVENT MATERNAL MORTALITY**

- Ensure that there are four basic EmOC facilities and one comprehensive EmOC facility for every 500,000 persons in the population (see glossary), and ensure that they are well-distributed among districts.

- Ensure that all women who experience obstetric complications can reach and be treated in EmOC facilities.

- Ensure that death occurs less than 1% of the time among women who undergo obstetric emergencies at a given health facility.

- Reach a rate of cesarean delivery of at least 5% of all births.

- Ensure that at least 15% of births take place in EmOC facilities.

Substantial constraints exist on the availability and quality of information to confidently describe the problem [of maternal mortality] …. Some of these limitations can seem overwhelming and to dwell on them can give the false impression that nothing is known. Clearly, enough is known to act.

lives and health. Governments can realize these obligations progressively, as the International Covenant on Economic, Social and Cultural rights notes, “to the maximum of its available resources.” That is, no one expects that a developing country can transform its maternal health system overnight. But “progressively” means that governments are continually moving in the right direction, using all available funds, with clear plans that have adequate budget support, adequate numbers of skilled birth attendants, EmOC services that grow in quality and quantity, and evidence-based interventions that are administered respectfully and competently. In addition, donor countries have a human rights obligation to assist developing countries in finding ways to ensure access to care for all women.

While health care interventions are crucial, maternal death and injury will be averted only if governments act to guarantee women’s human rights more broadly. A government that intends to reduce life-threatening complications of pregnancy must also create laws and policies that guarantee women's right to comprehensive health services, including contraception; protect women from violence, subordination, and discrimination; and ensure women's equal place in political decision-making at all levels. A rights-based approach to maternal mortality also includes working mechanisms to provide legal redress to women who are denied access to services as well as monitoring mechanisms led by civil society through which governments can be held accountable.

Civil society and community-based organizations can play an important part in monitoring a government’s fulfillment of its duty to prevent maternal deaths, especially by keeping a watchful eye on access to care for women who live in poverty or in remote rural areas. Governments that neglect maternal death and injury are neglecting human rights that they have pledged to uphold. They are liable to answer for this neglect to human rights commissions and other authorities, and civil society in many countries is increasingly poised to help these cases proceed.
Governments are obliged to respect, protect and fulfill human rights related to universal access to health services that help prevent maternal death and injury:

- **Women have the right to life (ICCPR, article 6).**
- **Women have the right to the highest attainable standard of health, as well as health services that are accessible, affordable, of good quality and acceptable (ICESCR, article 12; CEDAW, article 12).**
- **Women have the right to be free from discrimination on the grounds of sex, race, nationality, income or property, religion, health status, social origin and other status, including in the provision of health services (ICCPR, article 2).**
- **Women have the right to enjoy the benefits of scientific progress, including in the area of emergency obstetric care (ICESCR, article 15).**
- **International assistance and cooperation must be part of the progressive realization of the right to health services in low-income countries (ICESCR, article 2).**
In Bangladesh, one of the poorest countries in the world, more than 90% of births take place in the home, which presents a barrier to ensuring access to skilled care, including EmOC. Government actions have nonetheless shown that progress can be made to reduce maternal mortality in spite of entrenched poverty. With assistance from the United Nations Population Fund (UNFPA), national authorities invested in obstetric care at district-level Maternal and Child Welfare Centers (MCWC), which previously had provided mostly contraceptives and basic child health care. Basic supplies for these centers, including beds and medical equipment, were furnished, and MCWC workspaces were redesigned to include rooms for labor and delivery. The biggest challenge was to train staff in basic EmOC and establish a reliable process for referring patients to more centralized hospitals for procedures not handled at the MCWC. Residential facilities were constructed so that MCWC staff could offer 24-hour care, and staff were given incentives to take on their new responsibilities. These steps at the MCWC level and improvements in EmOC at more centralized levels raised the rate of facility-based childbirth threefold in the districts covered and improved quality of nonobstetric as well as obstetric services.

Sri Lanka was a very low-income country when it set out to reduce maternal deaths in the late 1950s. The government invested strategically in training midwives and placing them at the community level where they could gain people’s confidence and help raise awareness over time about obstetric emergencies. Midwives could rely confidently on a solid system of referral to services they could not perform. Midwives’ workloads were manageable and their salaries adequate, preventing high staff turnover. Higher-level Sri Lankan officials were very motivated to ensure access to health services at decentralized facilities as they needed rural votes to stay in office. With consistent support to sustain services and motivate front-line health professionals, maternal mortality in Sri Lanka fell from an estimated 1,076 per 100,000 live births in 1949 to 27 per 100,000 live births in 1992.

In too many countries, fees for health services block women’s access to life-saving obstetric care. User fees discriminate against the poor. The UN Committee on Economic, Social and Cultural Rights, which oversees states’ implementation of the right to health, notes that governments are obliged to ensure affordability of health services for all, including “socially disadvantaged groups.” People living in poverty must not be excluded from essential services or disproportionately burdened with fees for health service. The widely ratified Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obliges states parties to provide free services to pregnant women “where necessary” (Article 12), an important commitment that is too often unfulfilled. As an urgent priority, governments must find ways to ensure that women do not die for lack of money to pay for skilled care before and after birth or EmOC, and it is a human rights obligation of donor countries to assist them toward this end.

Credible studies in many countries have concluded that the contribution of user fees to government budgets is often more than offset by the human cost of excluding low-income people from health services. Preventing maternal death and injury is a challenging area in which to eliminate fees because proper care requires specialized personnel and equipment, but abolishing fees is necessary to guarantee the access to obstetric and other health services to which all women have a right.

Donor countries have an obligation to help low-income countries ensure that low-income women are never left behind in access to care. In places where eliminating user fees is not immediately feasible, governments are obliged, with help from donor states, to prevent user fees from posing a discriminatory barrier for low-income women. Governments can learn from the many efforts led by non-governmental organizations (NGOs) around the world in which community-controlled emergency funds or subsidy schemes
have assisted women in paying for EmOC. NGOs play an important role in advocating for both government action to support such efforts and international assistance toward eliminating all economic barriers to health services for women.

In obstetric emergencies, women are particularly dependent on others and on transportation and referral systems to ensure that they reach life-saving care. Governments must act urgently to change the all too common situation of better-off women having access to the best care while women living in poverty or in rural or remote areas die for lack of care. Referral systems that ensure access to care for rural women and others who live far from hospitals must be central to policies and programs, not afterthoughts. Women who are ethnic or racial minorities, of lower caste or class, in violent unions, or socially marginalized must not be left behind. Successful methods of addressing obstetric emergencies include mobilizing the community and creating community-level plans and structures to provide both financial and transportation assistance (see Box 3).

It should not be forgotten that the world’s most vulnerable women—those living in countries experiencing war or internal armed conflict—face extraordinary risks during pregnancy and childbirth. Because women in these situations rely on humanitarian assistance, it is the duty of the international community to ensure their human right to safety during pregnancy and childbirth. Unfortunately, skyrocketing rates of maternal mortality in conflict and post-conflict regions receive too little attention from international donors.

Affordable obstetric and reproductive health services are the right of all women, including women living in poverty:

- **Women have a right not to be excluded from essential health services because of poverty** (GC 14).
- **Women living in poverty have the right not to carry a disproportionate burden of health service costs** (GC 14).
- **Pregnant women have the right to health services at no cost to them where necessary to meet their need for care** (CEDAW, article 12).
- **Women have the right to medical attention in the event of illness** (ICESCR, article 12).
Communities living in poverty and marginalized by geographical remoteness face many health challenges. But programs in many low-income settings have shown that communities can be respectfully and sustainably engaged in reducing maternal deaths.

The ReproSalud Program in Peru has reduced maternal death through the remarkable achievements of more than 240 community-based organizations reaching more than 200,000 low-income women and 10% of the districts in the country. Led by the organization Movimiento Manuela Ramos, the program focuses not on delivering services but on empowering women and communities to assert their right to maternal health services. ReproSalud helps communities address a wide range of barriers to reproductive health services, including domestic violence and other household-level abuse, disrespectful treatment of poor women by health professionals, and misinformation about reproductive health. It also helps communities establish village banks and obstetric emergency funds.

A world away in the Saharan landscape of Mauritania, where many women live in poverty at great distances from maternity hospitals, a USAID-funded program supports local and regional organizations that combat maternal death at the village level. Village elders were engaged in raising people's awareness of the causes and signs of obstetric emergencies and the importance of having a plan to deal with emergencies. Villages established communal savings accounts that would assist women with transportation and other costs if they experienced obstetric emergencies. This kind of mobilization can be the difference between life and death for women in remote rural Mauritania.

The Warmi (meaning “woman” in two local languages) Project in Bolivia, a participatory maternal health program designed to strengthen women’s voice in community-based health actions, was facilitated in the early 1990s by Save the Children but sustained by local women’s groups. Although it was not possible to measure changes in maternal mortality in all the 500 communities that eventually joined the program, outcomes that could be measured, such as the proportion of births that took place in hospitals, improved markedly. From 2001 to 2003, Warmi’s methods were adapted to a much different setting—24 villages in the

**Box 3**

**COMMUNITY-BASED ACTION IN HUMAN RIGHTS-BASED RESPONSES**

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mountains of Nepal. There, with the establishment of village development committees facilitated by a local NGO and intensive awareness-raising among women’s groups, community mobilization contributed to a significant reduction in maternal mortality, mostly through improved relations between maternity hospitals and the community, and better transportation and referral systems.

Sources:  
Women in the last stages of pregnancy and in labor are vulnerable and in need of competent and sensitive care. Pregnant women who are bleeding profusely, burning with fever from an infection, or in the excruciating throes of prolonged labor are extremely vulnerable, and their lives depend on the actions of others. Women living in poverty, young women, and those with little formal education may be most vulnerable of all and possibly the least able to demand services or ask questions of service providers. Women with HIV/AIDS, women with scarring from female genital mutilation, and women who are victims of domestic violence may face elevated risk of obstetric emergencies and need special attention.

NGOs and researchers have documented horrible mistreatment of women in maternity facilities in many countries. Women are treated with disrespect, not consulted on the course of their care, and insulted as ignorant. In the worst cases, they are physically abused by the very people on whom they rely for critical care. In some countries, the doctors and other staff of maternity facilities do not speak the language of the women they serve, and translators are not available. Some health facilities show little regard for cultural practices and beliefs related to childbirth—for example, requiring women to give birth lying down when sitting or squatting is the custom they have inherited from their mothers. Women in some cultures may not be prepared to receive certain services from a male doctor or nurse but are not given a choice in this regard. Once present at an EmOC facility, women may experience delays in getting the urgent services they need. It is not surprising that in many countries, surveys have shown that even if obstetric services are available, women prefer to give birth at home with the assistance of someone they know and trust.

Midwives, doctors, and others who provide maternity care, including emergency obstetric care, often work under extremely...
difficult conditions without adequate protections for their own rights. They are often grossly overworked, underpaid, and poorly supervised and supported. They have specialized skills that often are neither recognized nor rewarded. They may face pressure to improve services without being given the resources to do so. They may not have the time or inclination to engage with representatives of the communities they serve. And they may never have been taught gender-sensitive and culture-sensitive approaches to care.

To meet their obligations to reduce maternal death and injury, governments must ensure that services are delivered respectfully and competently by staff who are well supported and not hardened by resentment of their working conditions. If women have reason to fear that they will be mistreated, no amount of information about the importance of skilled care during childbirth will be effective in getting them to seek life-saving obstetric services. If health professionals are not adequately compensated, trained, supervised, and supported, obstetric care will be unsustainable and of poor quality.

Good-quality obstetric and other health services administered in a respectful way are the right of all women:

- **Women have the right to health services that are appropriate, sensitive and respectful with regard to gender and culture (GC 14).**
- **Underlying determinants of health—education, food, water, shelter and the satisfaction of other basic needs—are part of women’s right to the highest attainable standard of health (GC 14).**
- **Women have the right to special protection during a reasonable period before and after childbirth (ICESCR, article 10).**
- **Health workers have the right to fair remuneration, and women health professionals have a right to equal remuneration to that of men for equal work. All workers have the right to rest, leisure and reasonable limitation of working hours and to safe and healthy work conditions (ICESCR, article 7).**
Ensuring women’s right to determine the number and spacing of their children and to autonomy in their sexual lives is essential to reducing maternal mortality.

An estimated 200 million women in the world would like to delay or prevent pregnancy but do not have access to effective contraceptives. The United Nations estimates that maternal mortality would be reduced by about a third if unwanted pregnancies were eliminated. A woman has the right to autonomy in seeking and using reproductive health services and contraception, as well as in refusing sex. Too often, women are stripped of this autonomy.

Men may not want their wives or long-term partners to have access to contraception or abortion. In some places, health facilities or community norms may effectively require that a woman get her husband's or partner's permission for access to contraception or legal abortion. Young women may be discriminated against in access to reproductive health services. The lack of access to safe and legal abortion in many countries contributes to maternal mortality both in unwanted pregnancies and through clinical complications that cause obstetric emergencies. An estimated 19-20 million unsafe abortions occur annually worldwide, resulting in about 68,000 deaths and thousands of injuries. Many women have no access to basic scientifically sound and nonjudgmental information about reproduction and reproductive health services, an essential right in itself and a central element of reproductive health care. Access to comprehensive reproductive health services is the right of every woman, but it is a distant dream for millions.

Many women who are denied the ability to seek and use reproductive health services also lack control over sex in their daily lives. Some women cannot refuse sex without facing violence or coercion. Women may fear defying a sex partner on whom they are economically dependent—a dependence that is often cemented
by discrimination against women in education and employment. Young women or girls subjected to child marriage may be especially vulnerable to sexual subordination. Many women cannot demand condom use of their partners.

Autonomy in sexual decision-making and access to comprehensive reproductive health services are the right of all women. Efforts to increase women’s access to information, sexual education, and safe clinics must be accompanied by measures to empower women and protect them from violence.

Autonomy in sexual decision-making and access to comprehensive reproductive health services are the right of all women:

• **Women have the right to decide the number and spacing of their children (CEDAW, article 16).**

• **Women have the right to be free of domestic violence and sexual violence and coercion (UN Declaration on the Elimination of Violence against Women, 1993).**

• **Women have the same right as men to enter into marriage and to be married only with their free and full consent (CEDAW, article 16). The African Charter on the Rights and Welfare of the Child (article 21) and many national laws specify a minimum age of 18 for marriage. CEDAW (article 16) also notes that the betrothal of a child has no legal effect.**
As already noted, simply making available good-quality emergency obstetric care, skilled attendance at childbirth, and access to reproductive health services will not reduce maternal mortality unless governments act to ensure the broader empowerment of women. That maternal deaths remain a problem of such staggering proportions has as much to do with the political powerlessness of women as with the technical challenges of health services. Women must no longer be on the outside of the structures of power hoping that their rights will be respected, but rather must be part of political decision-making at all levels and share control of policies and programs that affect their health and survival. Women must have a significant role in eliminating gender-based discrimination in access to education, housing, food, water, and other determinants of health.

National and subnational human rights commissions and other institutions of justice should investigate cases of women’s exclusion from life-saving health services and comprehensive reproductive care. The state must not impede actions of civil society organizations, including women’s organizations, that work to ensure that women are not disempowered by poverty, violence, and discrimination. All governments must ensure that national laws and policies embody women’s rights fully, including women’s right to comprehensive health services and to protection from discrimination with respect to underlying determinants of health. Donor countries must therefore do more than invest in health-care services; they must assist low-income countries in finding the resources needed to make respect, protection, and fulfillment of women’s rights a reality.

When women enjoy their right to participate in public life and decision-making, pregnancy will be safer for all.
If human rights are to be truly universal, they have to be applied both to require states to take effective … measures to reduce maternal mortality, and to afford women themselves the capacity to protect their reproductive health. … Countries [must] recognize that they are violating their own values by allowing unsafe motherhood.

—Rebecca Cook, University of Toronto Faculty of Law
Governments must create mechanisms that enable women to lead the struggle against maternal mortality. Women should be supported and encouraged to develop community-based plans for handling obstetric emergencies and monitoring delivery of health-care services, as well as to address subordination and discrimination more broadly.

Governments have a responsibility to ensure that women are empowered to take into their own hands the struggle against maternal death and injury:

- **Women have the right to take part in the formulation and implementation of government policy (CEDAW, article 7).**

- **Rural women have the right to “all appropriate measures” needed to ensure that they enjoy services that other women enjoy, including participation in public policy decision-making (CEDAW, article 14).**
There can be no more excuses for needless maternal deaths. Governments must act urgently on their health and human rights commitments to reduce maternal mortality, and must ensure that women’s voices are heard in program and policy decision-making. Donors must stand ready to support these efforts.

In 2000, the member states of the United Nations agreed to a set of Millennium Development Goals (MDGs) meant to guide the efforts of all countries to meet the needs of the world’s poorest people. The progress toward Goal 5, “Improve Maternal Health,” will be measured by reduction in the rate of maternal mortality in the population, with the process indicator of percentage of births at which skilled attendants are present, as well as by the target of access to reproductive health for all by 2015. This commitment builds on pledges made at other UN summits, but the MDGs offer an unusual opportunity to galvanize a broad-based response to maternal death and injury.

Recent reports on progress toward realizing the MDGs indicate that Goal 5 is showing the lowest rate of progress of all the goals, and Africa and South Asia—the regions with the highest burden of maternal death—are progressing most slowly of all. The United Nations estimates that an additional USD 5.5 billion to 6.1 billion will be needed each year until 2015 to achieve the 75% reduction in maternal mortality associated with Goal 5. It is not an option for the world to fail to reach this very feasible level of funding. International cooperation, a central element of human rights-centered development, remains handicapped by the failure of almost all donor countries to devote 0.7% of their gross national products to foreign assistance programs, a goal long agreed upon by UN member states. And within foreign assistance, maternal mortality is too low a priority for many donors.
The voices and views of women, particularly those in low-income countries, must be at the center of subnational, national, and international planning and action to reduce maternal death and injury. It is only they who fully understand how to remove the barriers to care during pregnancy and childbirth, including poverty, marginalization, and disempowerment.

There can be no standing by while women, mostly poor and rural women, die in great numbers. What needs to be done is known. The inequity, discrimination, and abuse that underlie these deaths can be addressed. Where women's lives are valued, their dignity respected, and their human rights ensured, the promise of safe pregnancy and childbirth can be fulfilled.
Basic emergency obstetric care: Basic EmOC facilities provide the following services:

- parenteral (intravenous or by injection) antibiotics
- parenteral oxytocic drugs
- parenteral anticonvulsants
- manual removal of placenta
- removal of retained products
- assisted vaginal delivery (vacuum extraction, forceps delivery)

Comprehensive emergency obstetric care: Comprehensive EmOC includes basic EmOC plus cesarean section and blood transfusion.

Maternal death: Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental cause.

Skilled birth attendant: A health professional with midwifery skills (doctor, midwife, or nurse) who has been trained to proficiency to manage normal deliveries and diagnose or refer obstetric complications.

References and additional readings


The International Initiative on Maternal Mortality and Human Rights (IImmHR) is the first civil society human rights effort aimed at reducing maternal mortality. We seek to ensure that the policies and practices of key stakeholders successfully address maternal mortality as a human rights issue.

**Steering Committee:**

- Averting Maternal Death and Disability Program, Columbia University
- CARE
- Center for Justice and International Law
- Center for Reproductive Rights
- Equinet, the Regional Network on Equity in Health in Southern Africa
- Family Care International
- Health Equity Group
- Human Rights Centre, University of Essex
- International Budget Partnership
- The Kvinna till Kvinna Foundation
- Likhaan
- Physicians for Human Rights
- SAHAYOG

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