



# The Safe Motherhood Initiative

When the Safe Motherhood Initiative was launched in 1987, death from the complications of pregnancy and childbirth was a little-known, seriously neglected problem. Ten years later, preventing these deaths is an international priority, and many countries have made significant progress in expanding and improving maternal health services. The global Initiative has become a unique partnership of governments, donors, technical agencies, non-governmental organisations and women's health advocates in more than 100 countries. These partners are now working to protect the health and lives of women, especially during pregnancy and childbirth.

## What We Know

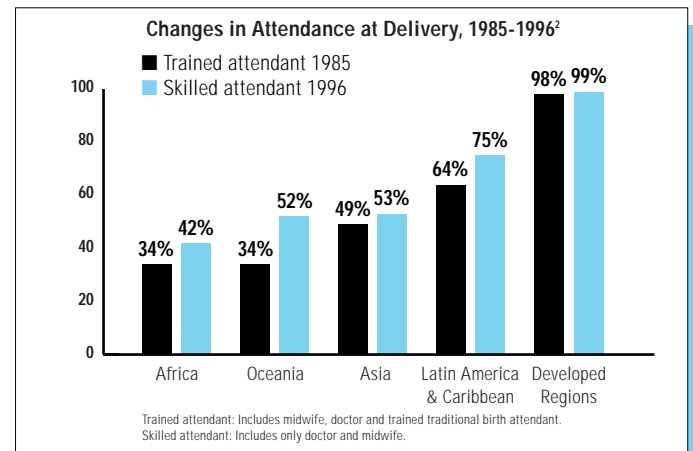
- **Complications of pregnancy and childbirth are the leading causes of disability and death** among women between the ages of 15 and 49 in developing countries.<sup>1</sup>
- **Every woman is at risk.** During pregnancy, any woman can experience life-threatening and unpredictable complications that require immediate medical care.
- **In order to reduce deaths, good-quality maternal health services must be readily available — and must be used — especially during and immediately after childbirth.** Services should be provided by trained health workers, clinics and

hospitals located as close as possible to where women live, and must be linked by an emergency referral and transport system.

- **Safe motherhood strategies must be comprehensive.** Even when good quality health services are available, social, economic and cultural limitations can prevent women from using these services. Safe motherhood programmes emphasise the need for action on these root causes, and also on other reproductive health problems, including unwanted pregnancy and sexually transmitted diseases.

## The Next Ten Years

- **In the last several years, safe motherhood has been embraced by governments all over the world.** They have initiated programmes to reduce maternal death, improve reproductive health services, and protect and promote women's health and well-being, especially during pregnancy and childbirth.
- **To help governments and private organisations meet their maternal health goals,** safe motherhood partners from around the world met in October 1997 to identify the most efficient and cost-effective ways to improve maternal health. Participants discussed research results, new technologies, model programmes and lessons learned during the Initiative's first decade. The meeting identified ten essential action messages for improving maternal health (fact sheets on these messages are available for both general and technical audiences), and led to an agreement on the key health services that should be available to make motherhood safer. This package of services is described in the box on the following page.



■ **A comprehensive package of services for safe motherhood should include:**

— *During Pregnancy: Antenatal care and counselling.*

During pregnancy, health workers should: educate women about how to stay healthy during pregnancy; help women and families prepare for childbirth; and raise awareness about possible pregnancy complications and how to recognise and treat them. Health workers should also identify and manage any complications early and improve women's reproductive health and well-being through preventive measures (iron supplements, tetanus immunisation) and by detecting and treating existing problems (such as sexually transmitted diseases).

— *During Childbirth: Skilled care during labour and delivery.*

During childbirth, every woman should be helped by a health professional who can manage a normal delivery as well as detect and manage complications such as haemorrhage, shock and infection. Skilled attendants should have access to a functioning emergency and transport system so that they can refer women to an appropriate health facility for higher level medical care (such as Caesarean delivery or blood transfusion) when necessary.

— *After Delivery: Postpartum care.*

Following childbirth, women should be seen by a health worker, preferably within three days, so that any problems (such as infection) can be detected and managed early. An additional postpartum visit within the first six weeks after delivery enables health workers to make sure that the mother and baby are doing well, to provide advice and support for breastfeeding and to offer family planning information and services.

— *Before and After Pregnancy: Family planning.*

Family planning counselling and services should be available to all couples and individuals, including adolescents and unmarried women. Family planning services should offer complete information and counselling as well as a wide choice of modern contraceptives, including emergency contraception, and should be part of a comprehensive programme that addresses other sexual and reproductive health needs.

— *Throughout the Reproductive Life Span: Abortion-related care.*

High-quality services for treating and managing complications of unsafe abortion should be available through all health systems. Services require: staff who are trained and authorised to treat complications; appropriate equipment; protocols for care; and effective referral networks. Women with abortion complications should also have access to other reproductive health services, including family planning.

Where abortion is not against the law, safe services for pregnancy termination and compassionate counselling should be available.\* Health workers must be informed about the legal status of abortion and protocols for providing it. Appropriate technologies, including new methods such as non-surgical abortion, should be available where feasible.

— *During Adolescence: Reproductive health education and services\*.*

All young people should have information on sexuality, reproduction, contraception, decision-making skills and gender relations in order to help them make informed decisions about sexuality and to negotiate abstinence or safer sex. Sensitive, respectful and confidential reproductive health counselling and services for married and unmarried adolescents should emphasise the prevention of unwanted pregnancy, unsafe abortion and sexually transmitted diseases (STDs).

— *For Women and Families: Community education.*

Key health topics for women and their families include how to prevent unwanted pregnancy and avoid unsafe abortion; how to recognise complications of pregnancy, childbirth and unsafe abortion and where to seek treatment; and the dangers of certain traditional practices during pregnancy and childbirth. Education is also needed for decision-makers — from husbands to community leaders to national policy-makers — to promote safe motherhood and improvements in women's health and status.

\*Each co-sponsor of the Safe Motherhood Initiative implements these activities according to its specific mandate.

Sources:

1: *World Development Report 1993: Investing in Health.* World Bank, Washington, DC, 1993.

2: "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition". World Health Organization, Geneva, 1997.

**The Safe Motherhood Co-sponsors**

The Safe Motherhood Initiative is led by a unique alliance of co-sponsoring agencies who work together to raise awareness, set priorities, stimulate research, mobilise resources, provide technical assistance and share information. Each of these agencies implements safe motherhood activities according to its specific mandate. The co-sponsors include:

United Nations Children's Fund (UNICEF)  
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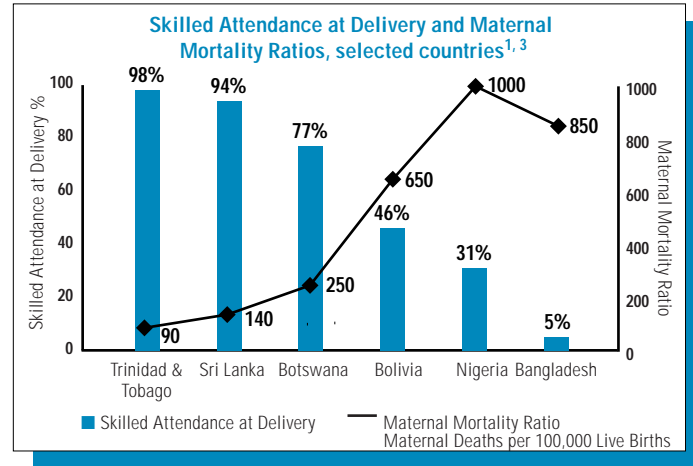
# Skilled Care During Childbirth

The single most important way to reduce maternal deaths is to ensure that a skilled health professional is present at every birth. However, there is a serious shortage of these professionals in developing countries. Whether by choice or out of necessity, 60 million women in the developing world give birth each year without skilled help—cared for only by a traditional birth attendant, a family member, or no one at all.<sup>1</sup>

Skilled care during childbirth is important because millions of women and newborns develop serious and hard-to-predict complications during or immediately after delivery. Skilled attendants—health professionals such as doctors or midwives who have midwifery skills—can recognise these complications, and either treat them or refer women to health centres or hospitals immediately if more advanced care is needed.

## Unassisted Births Are Common and Can Be Fatal

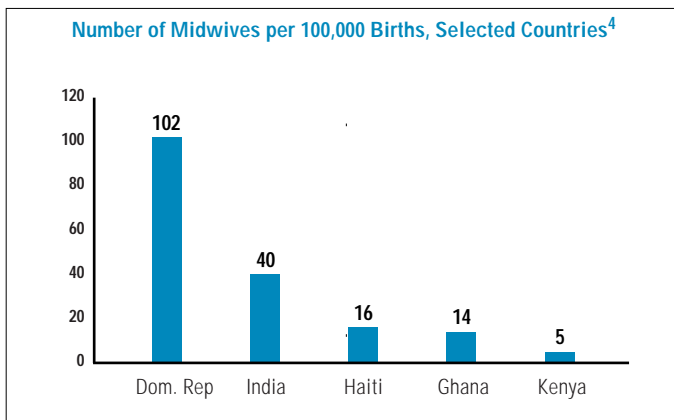
- More than three-quarters of all maternal deaths in developing countries take place during or soon after childbirth.<sup>2</sup>
- In 1996, skilled birth attendants were present at only 53% of births in the developing world.<sup>1</sup> In developed countries, skilled attendance is nearly universal.
- Countries where skilled attendance at delivery is low tend to have higher rates of maternal death and disability.



## Who Should Provide Care During Childbirth?

- The best person to provide assistance during childbirth is a health professional with midwifery skills who lives in or near to the community he or she serves.
- Most midwives work in hospitals and urban areas. They are scarce in rural areas—where 80% of developing country populations live.
- Adequate equipment, drugs and supplies are essential to enable skilled attendants to provide good quality care. In addition, skilled attendants need to be supported by appropriate supervision. When delivery is taking place in the village (at home or in a local health facility), an emergency transport system must be available to take women to facilities that can provide more advanced care.
- Skilled attendants include doctors, nurses, midwives and other health workers with midwifery skills who can diagnose and manage complications during childbirth, as well as assist normal deliveries.<sup>6</sup>

*In parts of Asia and Africa, there is only one midwife for every 15,000 births.<sup>5</sup>*



## Care in the Community

■ **In developing countries, women commonly seek the help of traditional birth attendants: community members who deliver infants according to local customs and beliefs.** In some — but not all — communities, these attendants may have some training to help them avoid harmful practices, conduct clean deliveries, recognise danger signs and refer women to health facilities if they have any complications. However, without emergency back-up support (including referral to a district hospital), training traditional birth attendants does not decrease a woman's risk of dying in childbirth.<sup>7</sup>

■ **In many places, especially in Asia and Africa, women give birth with the help of a relative, or alone.**

Deliveries by Relatives or Alone, Selected Countries<sup>8</sup>

	Delivery by relative/other (%)	Delivery alone (%)
Malawi	41	7
Uganda	35	12
Niger	24	17
Nepal	56	11
Pakistan	52	2

## Training Needs

■ **As countries try to ensure that a qualified health professional is present at the birth of every child, they face a number of significant problems:**

- **Existing health workers often lack the skills they need to save the lives of women who suffer emergency complications.** These skills include the ability to prevent, identify and treat problems such as shock, haemorrhage, infection (sepsis), and eclampsia (convulsions from high-blood pressure), and to manage abortion complications.
- **Curricula used to teach midwifery skills are often out of date and do not reflect new techniques and research.** Many of these curricula are adapted from developed country models and do not reflect the limited resources and poor working conditions in developing countries.<sup>4</sup>

- **Supervision and refresher training in family planning and maternal health are often inadequate.**<sup>4</sup> In Uganda, for example, a study found that only 28% of midwives had ever taken a refresher course.<sup>9</sup>
- **Many midwives and physicians have no training in traditional belief systems, communication and community organising.**<sup>4</sup> These topics are needed to ensure that a health worker is an accepted part of the community she or he serves.

## What Can Be Done

■ **Increase the number of health professionals with midwifery skills** in under-served regions, particularly poor and rural areas.

■ **Train, authorise and equip midwives, nurses and community physicians to provide all feasible obstetric services** needed within communities, especially emergency interventions, and to prescribe medication. Establish systems for training, supervising and supporting these providers, and for linking them to higher-level health facilities for back-up.

- **Upgrade, establish and expand comprehensive midwifery training programmes** that include life-saving skills for dealing with obstetric emergencies.
- **Create clearly-defined protocols** for routine care and the management of complications.
- **Establish systems for supervising and supporting skilled birth attendants, and for emergency referral and treatment.**

### Sources:

- 1: "Coverage of Maternity Care: A Listing of Available Information, Fourth Edition". World Health Organization, Geneva, 1997.
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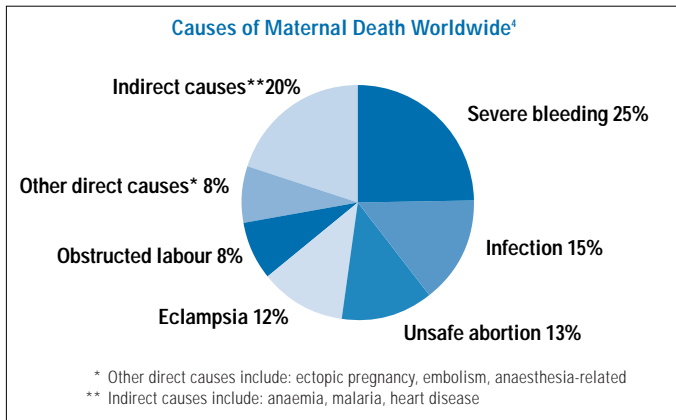
# Maternal Mortality

In many developing countries, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. More than one woman dies every minute from such causes; 585,000 women die every year.<sup>1</sup> Less than one percent of these deaths occur in developed countries, demonstrating that they could be avoided if resources and services were available.<sup>1</sup>

In addition to maternal death, women experience more than 50 million maternal health problems annually.<sup>2</sup> As many as 300 million women — more than one-quarter of all adult women living in the developing world — currently suffer from short- or long-term illnesses and injuries related to pregnancy and childbirth.<sup>3</sup>

## Maternal Death

- **Every woman can experience sudden and unexpected complications during pregnancy, childbirth, and just after delivery.** Although high-quality, accessible health care has made maternal death a rare event in developed countries, these complications can often be fatal in the developing world.



- **Women risk death and disability each time they become pregnant.** Women in developing countries face these risks much more often, since they bear many more children than women in the developed world.<sup>1</sup>

Women's Risk of Dying from Pregnancy and Childbirth <sup>1</sup>	
Region	Risk of Dying
All developing countries	1 in 48
Africa	1 in 16
Asia	1 in 65
Latin America & Caribbean	1 in 130
All developed countries	1 in 1,800
Europe	1 in 1,400
North America	1 in 3,700

*Country-level differences are even more dramatic: for example, in Ethiopia, 1 out of every 9 women die from pregnancy-related complications, as compared to 1 in 8,700 in Switzerland.<sup>1</sup>*

## Deaths of Infants and Children

- **Each year, almost 8 million stillbirths and early neonatal deaths (deaths within one week of birth) occur.** These deaths are caused largely by the same factors that lead to maternal death and disability—women's poor health during pregnancy, inadequate care during delivery and lack of newborn care.<sup>4</sup>

*A study in Bangladesh found that a mother's death sharply increased the probability that her children, up to age 10, will die within two years. This was especially true for her daughters.<sup>5</sup>*

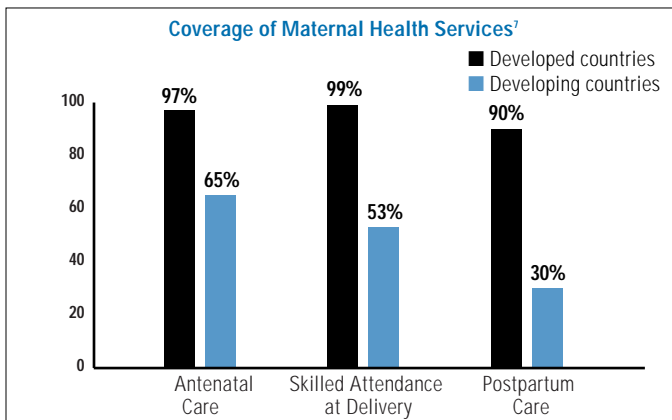
## Maternal Disabilities

- **At least 40% of women experience complications during pregnancy, childbirth and the period after delivery.** An estimated 15% of these women develop potentially

life-threatening problems.<sup>4,6</sup> Long-term complications can include chronic pain, impaired mobility, damage to the reproductive system and infertility.

## Why Are Women Dying?

- **Most maternal complications and deaths occur either during or shortly after delivery.** Yet many women do not receive the essential health care they need during these periods:



— **During pregnancy:** The percentage of women who seek antenatal care at least once is 63% in Africa; 65% in Asia; and 73% in Latin America and the Caribbean. At the country level, however, use of such services can be extremely low. In Nepal, for example, only 15% of women receive antenatal care.<sup>7</sup>

— **During childbirth:** Each year, 60 million women give birth with the help of an untrained traditional birth attendant or a family member, or with no help at all. Almost half of births in developing countries take place without the help of a skilled birth attendant (such as a doctor or midwife).<sup>7</sup>

— **After delivery:** The majority of women in developing countries receive no postpartum care. In very poor countries and regions, as few as 5% of women receive such care.<sup>7</sup>

## Why Do Women NOT Seek Services?

- **The factors that prevent women in developing countries from getting the life-saving health care they need include:**

- *distance from health services;*
- *cost* (direct fees as well as the cost of transportation, drugs and supplies);

- *multiple demands on women's time;*
- *women's lack of decision-making power within the family.*

- **The poor quality of services, including poor treatment by health providers, also makes some women reluctant to use services.**

## What Can Be Done

- **Ensure access to maternal health services.** Most maternal deaths, many health problems among women and children, and the deaths of at least 1.5 million infants each year could be prevented through:

- *routine maternal care for all pregnancies*, including a skilled attendant (midwife or doctor) at birth;
- *emergency treatment of complications* during pregnancy, delivery and after birth; and

- *postpartum family planning and basic neonatal care.*

Such care would cost about \$3 per person per year in low-income countries. Basic maternal care alone can cost as little as \$2 per person.<sup>8</sup>

- **Improve women's status and raise awareness about the consequences of poor maternal health.** Families and communities must encourage and enable women to receive proper care during pregnancy and delivery.

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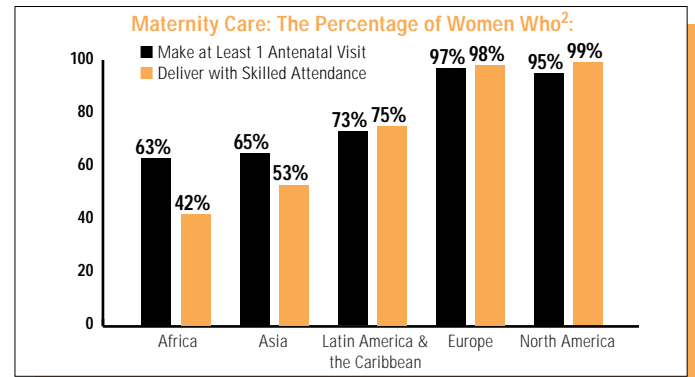
# Good Quality Maternal Health Services

Millions of women do not have access to good quality health services during pregnancy and childbirth — especially women who are poor, uneducated or who live in rural areas.<sup>1</sup> Less than half of women in developing countries get adequate health care during and soon after childbirth, despite the fact that most maternal deaths take place during these periods.<sup>1</sup> In contrast, use of maternal health services is nearly universal in developed countries.

Access means that services are available and within reach of women who need them. Good quality services require that health care providers have adequate clinical skills and are sensitive to women's needs; that facilities have necessary equipment and supplies; and that referral systems function well enough to ensure that women with complications get essential treatment.

## Many Women Lack Maternal Health Care

- **At least 35% of women in developing countries receive no antenatal care during pregnancy, almost 50% give birth without a skilled attendant and 70% receive no postpartum care in the six weeks following delivery.**<sup>2</sup> This lack of care is most life-threatening during labour, childbirth and the days immediately after delivery, since these are the times when sudden, life-threatening complications are most likely to arise.



## Why Women Do Not Use Available Services

- **No physical access:** Most rural women (80%) live more than five kilometres from the nearest hospital. Vehicle shortages and poor road conditions mean that walking is often the main mode of transportation, even for women in labour.<sup>1</sup>  
*In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility, but could not because of distance and the lack of transport.*<sup>3</sup>
- **High costs:** Millions of women cannot afford to use maternal health services. Even when formal fees are low or non-existent, women often face hidden fees and expenses for transport, drugs, and food or lodging for the woman or her family members.

	Obstetric services free (1983)	Fees for some services introduced (1985)	Increases in fees (1988)
Obstetric admissions	7,450	5,437	3,376
Deliveries	6,535	4,377	2,991
Maternal deaths	2	1	62

- **Poor information:** Women and community members often do not know how to recognise, prevent or treat pregnancy complications, or when and where to seek medical help.  
*In Ghana, 64% of women who died of pregnancy complications sought help from a traditional healer before going to a health facility. Families cited cost and their belief that the woman was not ill enough as the main reasons for not seeking hospital care.*<sup>4</sup>
- **Cultural preferences:** Formal health services can conflict with ideas about what is normal and acceptable, including preferences for privacy, modesty and female attendants.  
*The Saraguro Indians in Ecuador shun affordable, accessible maternity care because they feel that hospitals violate women's privacy during childbirth and because many health providers are men.*<sup>5</sup>
- **Lack of decision-making power:** In many parts of the world, women's power to make decisions is limited, even over matters directly related to their own health.  
*In Bangladesh, it is usually the mother-in-law and husband who make the decision to seek (or not seek) care. Studies have found that they are the least likely to know about pregnancy-related complications and their possible fatal consequences.*<sup>6</sup>

## Health Services Are Inadequate

- **Poor quality of care is one of the most common reasons women give for choosing not to use available maternal health services.** Problems include:
  - **Health facilities in developing countries face chronic shortages of equipment, drugs and basic supplies, including blood for transfusion.** Families of women in labour may be forced to purchase drugs and supplies to bring to the hospital,<sup>7</sup> which can cause fatal delays.
  - **Health facility staff are often poorly trained.** They may lack both life-saving and basic clinical skills, and may not observe hygienic practices.
  - **Health workers may be rude, unsympathetic and uncaring,** so women prefer to use the services of traditional birth attendants and healers.

Improving the quality of existing maternal health services is the quickest, most cost-effective way to save women's lives:

Good quality care aims to:<sup>11</sup>

**Meet women's needs:**

- Services should be provided in health facilities that are as close as possible to where women live and that can provide the services safely and effectively;
- Services should be sensitive to cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers;
- Staff should be respectful, non-judgmental and responsive to clients;
- Women should be treated as active participants in their own health, and offered information and counselling so they can make informed decisions about their health and treatment.

— **Other factors include:** a lack of privacy; run-down physical facilities; inconvenient operating hours; and restrictions on who can stay with a woman at the health facility.<sup>8</sup>

- **Delays in referring women from community health facilities to hospitals are one of the most important barriers to life-saving maternal care.**

*In Masvingo, Zimbabwe, a significant proportion of maternal deaths were caused by "avoidable factors", including failure by health workers to identify women suffering from serious pregnancy-related complications and to refer them to a higher level of the health care system.<sup>9</sup>*

- **A study of 718 maternal deaths in Egypt found that 92% of them could have been avoided if good quality care had been provided.<sup>10</sup>**

**Provide technical competence:**

- Staff members should be trained in technical, clinical, management, and interpersonal skills;
- Standards of care and written protocols should be available;
- Physical facilities should be adequate, clean and convenient;
- Necessary drugs, equipment and supplies should be available;
- Comprehensive reproductive health services (including follow up care) should be available on-site or through established linkages to other health facilities;
- A fully functional referral and transport system should exist between all levels of care (home/community, health centres, and district/regional hospitals).

### What Can Be Done

- **Governments and non-governmental agencies must expand services, improve their quality, and tailor them to meet the needs of women and communities by:**

— **Ensuring that health facilities** are located close to where women live, have an adequate number of trained staff, a continuous supply of drugs and equipment, and are linked to hospitals by an emergency transport and referral system.

— **Enforcing standards and protocols** for service delivery, management and supervision, and using them to monitor and evaluate the quality of services, along with feedback from clients and health providers.

— **Providing free or affordable maternal and infant health services** that manage any complications as well as offer routine care.

— **Educating women and communities** about the importance of maternal health and appropriate services.

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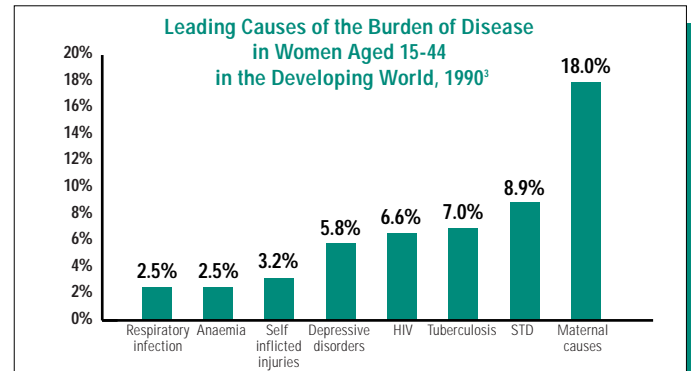
# Maternal Health: A Vital Social and Economic Investment

One-quarter of all adult women living in the developing world today suffer from some kind of illness or injury related to pregnancy and childbirth. Each year, maternal health complications are responsible for the deaths of 585,000 women, and contribute to the deaths of at least 1.5 million infants in the first week of life, and 1.4 million stillborn infants.<sup>1</sup> The social and economic cost of these disabilities and deaths — to families, communities, the labour force and countries — is enormous.

The financial cost of basic maternal and newborn health services that could prevent these problems is, on average, only US\$3 per person per year in developing countries; the cost of maternal health services alone can be as little as \$2 per person.<sup>2</sup> The total cost of saving the life of a mother or infant is approximately \$230.

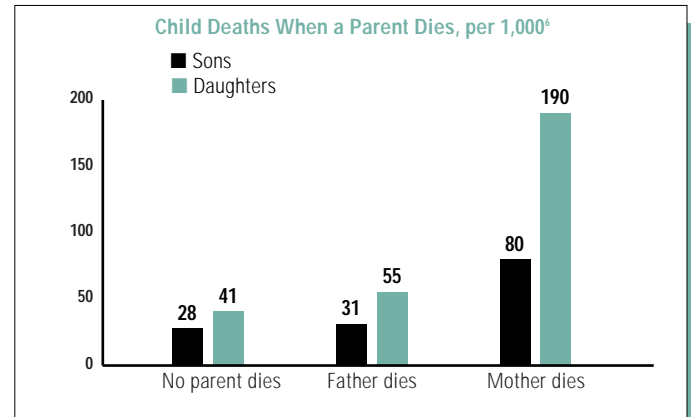
## Why Focus on Maternal Health?

- **In developing countries, pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age.** They account for at least 18% of the burden of disease in this age group — more than any other single health problem.<sup>3</sup>
- **Maternal health interventions are among the most cost-effective investments in health.**



## The Toll on Children

- **At least 30 to 40% of infant deaths are the result of poor care during pregnancy and delivery.** These deaths could be avoided with improved maternal health, adequate nutrition and health care during pregnancy, and appropriate care during childbirth.<sup>4</sup>
- **Poor maternal health and nutrition contributes to low birth weight in 20 million babies each year — almost 20% of all births.** These babies die more often than babies of normal weight, and are at greater risk for infection, malnutrition and long term disabilities, including visual and hearing impairments, learning disabilities and mental retardation.<sup>5</sup>
- **Motherless children are likely to get less health care and education as they grow up.** A study in Bangladesh found that when a mother dies, her children — especially daughters — are much more likely to die than children whose parents are both alive.<sup>6</sup>



## The Economic Cost

- **Women account for 70% of the 1.3 billion people who live in absolute poverty.**<sup>7</sup> When women cannot work because of health problems, the loss of their income, as well as the costs of treatment, can drive them and their families into debt.

*In India, a study found that disability reduced the productivity of the female labour force by about 20%.<sup>8</sup>*

- **At least 60% of pregnant women in the developing world are anaemic,** which reduces their energy — and can depress their incomes.

*Studies in Sri Lanka and China found that anaemia reduced productivity among women tea plantation and*

mill workers. The studies also documented the positive impact of iron supplements.<sup>9</sup>

- **When women cannot work the consequences can be especially severe for children.** Women are more likely than men to spend their own income on improving family welfare

## Benefits for Governments and Health Systems

- **Prevention and early treatment are cost-effective.** Millions of premature deaths, illnesses and injuries can be avoided by helping women prevent unwanted pregnancy and get prompt treatment for reproductive health problems. These steps also help governments avoid the higher costs of treating serious, undetected health conditions, and the costs of providing health care and social services for women with long-term disabilities, and for their families in case of their deaths.
- **Good maternal health services can strengthen the entire health system.** A health facility that is equipped to provide essential obstetric care — such as blood transfusions, anaesthesia and surgery — can also treat accidents, trauma and other medical emergencies for the community.
- **Building women's trust promotes preventive care.** Women who receive good care during pregnancy and childbirth are more likely to seek services for children's health, family planning and other health problems, including treatment of sexually transmitted diseases.<sup>1</sup>

### What Can Be Done

- **Governments, non-governmental organisations, international agencies and other funders must make a concerted effort to:**
  - **Acknowledge the social and economic benefits** of good maternal health, and include efforts to ensure maternal health in all national policies and plans.
  - **Allocate resources to make maternal health services available**, especially in poor and rural areas. Existing health care resources can be used to support the most cost-effective interventions.
- **Ensure that every woman has access to a continuum of good-quality safe motherhood services** offered at the community level, in health centres and in district and regional hospitals.

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# Safe Motherhood: A Matter of Human Rights and Social Justice

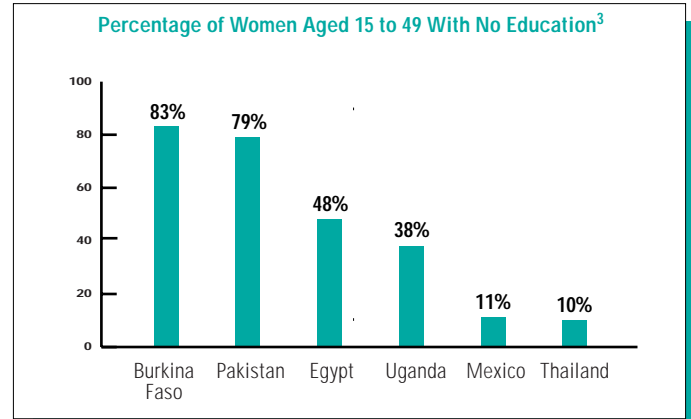
For a woman to die from pregnancy and childbirth is a social injustice. Such deaths are rooted in women's powerlessness and unequal access to employment, finances, education, basic health care and other resources. These factors set the stage for poor maternal health even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun.

Making motherhood safer, therefore, requires more than good quality health services. Women must be empowered, and their human rights — including their rights to good quality services and information during and after pregnancy and childbirth — must be guaranteed.

## The Powerlessness of Women<sup>1</sup>

■ **Millions of women in the developing world do not have the social and economic support they need to seek good health and safe motherhood.** Physical and psychological barriers include:

- **Limited exposure to information and new ideas:** In many communities pregnancy is not seen as requiring special care, and women do not recognise danger signs during pregnancy. Even if they are experiencing pain and suffering, they may have been taught that these conditions are inevitable, and therefore do not seek medical care.
- **Limits on decision-making:** In many developing countries, men make the decisions about whether and when their wives (or partners) will have sexual relations, use contraception or bear children. In some settings in Asia and Africa, husbands, other family members or elders in the community decide where a woman will give birth and must give permission for her to be taken to a hospital.
- **Limited access to education:** In much of Africa and Asia, 75% of women age 25 and over are illiterate.<sup>2</sup> When girls are denied schooling, as adults they tend to have poorer health, larger families and their children face a higher risk of death.
- **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 that are insensitive to women's needs, or staffed by rude health providers, do not offer women a real choice:** In many cultures, women are reluctant to use health services because they feel threatened and humiliated by health workers, or pressured to accept treatments that conflict with their own values and customs.

### HOW CAN EMPOWERING WOMEN MAKE MOTHERHOOD SAFER?<sup>1</sup>

It enables women to:

- speak out about their health needs and concerns.
- seek services with confidence and without delay.
- demand accountability from service providers, and from governments for their policies.
- participate more fully in social and economic development.

## Political Commitment to Safe Motherhood<sup>4</sup>

- **National policy-makers can establish a legal and political basis for safe motherhood by defining maternal mortality as a “social injustice”, as well as a “health disadvantage”.** By doing so, they will commit their governments to:
- **Identifying the powerlessness that women face** — throughout their lives as well as during pregnancy — as an injustice that countries must remedy through political, health and legal systems.

- **Ensuring that all women have the right** to make decisions about their own health, free from coercion or violence, and based on full information.
- **Guaranteeing that all women have access** to good quality care before, during and after pregnancy and childbirth.

# Using International Human Rights to Advance Safe Motherhood<sup>4</sup>

■ **International human rights treaties can be used to advance safe motherhood (see below). These documents, as well as most national constitutions, guarantee:**

- **The right to life, liberty and the security of the person.** These rights require governments to provide access to appropriate health care, and to guarantee that citizens can choose when and how often to bear children.
- **Rights that relate to the foundation of families and of family life.** These rights require governments to provide access to health care and other services women need to establish families and enjoy life within their families.
- **The right to health services (including information and education) and the benefits of scientific progress.** These rights require governments to provide reproductive and sexual health care to women.
- **The right to equality and nondiscrimination.** These rights require governments to ensure that *all* women and girls have access to services (such as education and health care)—regardless of age, marital status, ethnicity or socio-economic status.

■ **Recent international conferences and conventions set explicit goals that support and protect women's reproductive health needs.**

— Governments participating in the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women agreed that women and men have the right to decide if, when and how often to bear children, and should have access to reproductive health services. They also pledged to cut the number of maternal deaths in half by the year 2000, and in half again by 2015. Although these commitments are non-binding, the Committee on the Elimination of Discrimination Against Women, which monitors the Women's Convention (see below), is using them as standards for the 161 countries that signed the Convention.

## THE FOLLOWING INTERNATIONAL TREATIES PROVIDE FRAMEWORKS THAT CAN BE USED TO ADVANCE SAFE MOTHERHOOD:<sup>4</sup>

- Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention);
- 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; and
- African Charter on Human and Peoples' Rights.

Each is monitored by a group that develops performance standards for member countries and tracks compliance through periodic reports provided by each country.

## What Can Be Done

■ **Governments must provide a framework for ensuring safe motherhood by:**

- **Reforming laws and policies that contribute to maternal mortality** (e.g. those that restrict women's access to reproductive health services and information) and implementing laws and policies that protect women's health (such as prohibitions against child marriage and female genital mutilation).
- **Guaranteeing all women access to good quality maternal health care and accurate information**, and involving women in planning, implementing, monitoring and evaluating health programmes.

■ **Community leaders, women's advocates, private organisations and individuals must:**

- **Allow women greater freedom** to make their own health and life choices, encourage them to question unfair practices, and give them opportunities to learn about their rights and health and to develop a feeling of entitlement to medical care and other services.
- **Help men understand their role in expanding choices for women**, and in ensuring responsible sexual and family life.

■ **Everyone, including women's health advocates and donors, must:**

- **Hold governments accountable for effectively protecting the human rights of their citizens** by reporting any violations to constitutional courts and international monitoring bodies.

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# Unsafe Abortion

Each year, approximately 20 million unsafe abortions are performed worldwide.\* They result in nearly 80,000 maternal deaths and hundreds of thousands of disabilities.<sup>1</sup> In some countries, unsafe abortion is the most common cause of maternal death.<sup>1</sup> It is also one of the most easily preventable and treatable.

## Deaths from Unsafe Abortion

- Every day, 55,000 unsafe abortions take place — 95% of them in developing countries. They are responsible for one in eight maternal deaths. Globally, one unsafe abortion takes place for every seven births.<sup>1</sup>

Unsafe Abortion: Regional Estimates of Mortality and Risk of Death<sup>1</sup>

	Risk of dying after unsafe abortion	% of maternal deaths due to unsafe abortion
Africa	1 in 150	13%
Asia*	1 in 250	12%
Latin America	1 in 900	21%
Europe**	1 in 1900	17%

\*Excludes Japan, Australia and New Zealand \*\*Primarily Eastern Europe

## Disabilities and Health Problems

- Between 10% and 50% of all women who undergo unsafe abortions need medical care for complications.<sup>1</sup>
  - *The most frequent complications* are incomplete abortion, infection (sepsis), haemorrhage and injury to the internal organs, such as puncturing or tearing of the uterus.<sup>1</sup>
  - *Long-term health problems* include chronic pain, pelvic inflammatory disease and infertility.
- In many African countries, up to 70% of women treated for abortion complications are younger than 20.<sup>2</sup>
  - *Younger, unmarried women often have poor access to family planning information and services.* They also have

fewer social contacts and less financial means to obtain an abortion safely.<sup>3</sup> Young women are also more likely to delay pregnancy termination until late in pregnancy when the risk of complications is higher.

### DANGEROUS METHODS AND PROCEDURES USED TO INDUCE ABORTION INCLUDE:

- Inserting objects (sticks, wires, knitting needles) into the uterus.
- Drinking poisonous or harmful substances (including herbs, bleach and hair dye)
- Taking dangerous doses of over-the-counter medicines
- Douching with poisonous and caustic substances (bleach)
- Inflicting physical abuse (falling down stairs, blows to belly, jumping from heights)

## The Cost to the Public Health System

- Treatment of abortion-related complications often requires several days of hospitalisation and staff time, as well as blood transfusions, antibiotics, pain control medications and other drugs.<sup>1</sup>

- In some hospitals in developing countries, treating the complications of unsafe abortion consumes as much as 50% of the total budget.<sup>4</sup>

## Legislation and Policies on Abortion

- Pregnancy termination is permitted in more than 131 developing countries (and almost every developed country) — either for broad economic or social reasons, or for more limited health or personal circumstances such as to protect the health of the woman or in case of rape or incest.<sup>5</sup> Definitions of “health risk” vary widely by country.

- Governments around the world have recognised that unsafe abortion is a major public health issue. At the 1994 International Conference on Population and Development, they called for humane, high quality medical services to prevent unsafe abortion and treat its complications. Participants also called for safe abortion services where not against the law.<sup>6</sup>

\*The World Health Organization acknowledges that data on unsafe abortion are scarce and subject to substantial error due to methodological constraints inherent in abortion-related research.

## Why Do Women Resort to Abortion?

**Most women who decide to terminate a pregnancy are married or live in stable unions and already have several children.<sup>1</sup>** Women can find themselves with an unwanted pregnancy for many reasons:

- **Family planning is out of reach:** At least 350 million couples worldwide do not have access to information about family planning and a full range of modern contraceptives.<sup>7</sup>
- **Contraceptive methods fail:** Between 8 and 30 million pregnancies each year are the result of contraceptive failure — either inconsistent or incorrect use of family planning methods, or failure of the methods themselves.<sup>8</sup>

- **Sexual coercion or rape:** In studies around the world, between 20% and 50% of women and girls report sexual abuse, rape or sexual coercion.<sup>9</sup>
- **A variety of social and economic reasons that include:** they are unmarried, have been abandoned by their partners, are adolescents, are in an unstable partnership, have too many children to support, and/or live in poverty.<sup>10,11</sup>

## Poor and Unavailable Health Services Make the Problem Worse

- **Even where legal, abortion is not always available:** In many developing countries, health workers, doctors and nurses do not have adequate training or equipment. Some refuse to perform abortions because they do not understand the laws or because they personally do not support abortion.<sup>12</sup>
- **Treatment for unsafe abortion is inadequate:** When women have complications from an unsafe abortion, good medical care is often unavailable. Lack of training, equipment and protocols; misdiagnosis; negative attitudes of health workers; and/or overcrowded emergency wards can result in life-threatening and costly delays for women seeking treatment.<sup>3</sup>
- **Family planning is not always offered to women who have been treated for abortion complications<sup>12</sup>:** In Zambia, for example, 78% of women treated for abortion complications said they wanted information about family planning; 44% wanted to receive a method. However, family planning was discussed with only 33% of the women, and none was offered a method to take home.<sup>11</sup>

### What Can Be Done

- **Ensure universal access to client-sensitive family planning services,** especially for young people and women at risk of sexual abuse, rape and violence.
- **Offer safe abortion services** by trained, compassionate staff when allowed by law;\*
- **Ensure that high-quality services for treating and managing abortion complications** are accessible through the health system.
- **Offer family planning counselling and services,** and referrals for comprehensive reproductive health services, to all women who have had an abortion.
- **Educate communities** about reproductive health and unsafe abortion.
- **Reform laws and policies** to support women's reproductive health and improve access to family planning, health and abortion-related services.\*

\*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

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# Measuring Progress

During the last decade, governments around the world have pledged to cut maternal mortality in half by the year 2000\*. However, accurate figures on maternal death are difficult to gather. Therefore, countries need other, more reliable and cost-effective ways to measure their progress toward reducing maternal mortality.

## What Is a Maternal Death?

■ **“The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”.**<sup>1</sup>

■ **Maternal death statistics are usually expressed as:**

— **A ratio:** The maternal mortality ratio is the number of maternal deaths per 100,000 live births. It indicates the risk of maternal death among pregnant women and those who have recently delivered.<sup>2,3</sup>

— **A rate:** The maternal mortality rate is the number of maternal deaths per 100,000 women aged 15-49 per year. It reflects both a woman’s risk of dying from maternal death and her risk of becoming pregnant.

— **A “lifetime risk”:** A woman’s lifetime risk of maternal death is the probability that she will die from complications of pregnancy or childbirth at some point during her entire reproductive life-span. It is often used to illustrate the differences in the risk faced by women in developed and developing nations.<sup>3</sup>

## Why Is Maternal Death Difficult to Measure?

■ **It is under-reported:** People in developing countries often die outside the health system, which makes accurate registration of deaths difficult. Under-reporting can be significant; in some studies, the actual number of maternal deaths was double or triple what was initially reported.<sup>4</sup>

■ **It is misclassified:** Health workers may not know why a woman died, or whether she was or had recently been pregnant. Even if the health worker does know, the infor-

mation is not always recorded. Deaths are sometimes intentionally misclassified, especially if they are associated with clandestine abortions.

■ **Methods used to calculate maternal death rates are often complex and costly to use.** The actual number of maternal deaths in a specific place at a specific time is relatively small. Therefore, very large populations must be surveyed in order to get accurate estimates.

## Which Estimates of Maternal Mortality Are We Using Now?

■ **The World Health Organization and UNICEF have developed a new way to estimate maternal mortality that compensates for under-reporting and misclassification.** Their estimates, for the year 1990, are generally accepted for countries without reliable data, but they still have wide margins of error. Therefore, they should only be used to describe the general size of the problem in each country in order to:<sup>3,5</sup>

— *sensitise policy-makers, programme-planners and others;*  
— *stimulate discussion and action; and*  
— *mobilise national and international resources.*

■ **Although these estimates can be used to monitor trends over more than a decade, they cannot provide information on short-term progress in reducing maternal mortality.**

## What Information Do We Need?

■ **In order to reduce maternal deaths, it is more important to understand why women are dying than to know exactly what the level of maternal mortality is.** Such information can be found through:

— **Process indicators**, such as the proportion of births that are assisted by skilled health personnel or that take place in health facilities.<sup>6,7</sup> Studies have shown that reducing maternal mortality depends primarily on women’s use of good quality maternal health services.

\*Including at the global Safe Motherhood Conference (1987), World Summit for Children (1990), International Conference on Population and Development (1994), World Summit on Social Development (1995) and Fourth World Conference on Women (1995).

— **Case reviews** of the causes and circumstances surrounding a select number of maternal deaths. There are two types of reviews: those that focus only on what happened once the woman reached the health facility (such as whether the doctor was available), and those that also investigate what happened beforehand (such as whether there was a delay in reaching the facility in the first place).<sup>8</sup> These reviews provide valuable information that can be used to identify and address problems, either with the quality of services or within communities.

## EVALUATING OBSTETRIC CARE:

In order to reduce maternal mortality, high quality obstetric services must be available to manage major complications. UNICEF, WHO, and UNFPA have developed a series of process indicators that focus on these essential obstetric services. Data for these indicators can be collected and analysed at health facilities without large-scale community surveys.<sup>2</sup>

This series includes indicators that measure:

- the availability of services;
- the use of services; and
- the performance of health facilities.

More information on this series can be found in "Guidelines for Monitoring the Availability and Use of Obstetric Services", UNICEF, New York, October 1997.

## Measuring Maternal Illness and Disability

■ **Pregnancy complications can cause serious, long-term health problems even when they do not result in death.** As such, it is important to try to assess the scope and impact of maternal disabilities, and to understand how they are perceived and dealt with by women and communities.

■ **However, it can be difficult to identify and classify maternal illnesses and disabilities.**<sup>5</sup> Even trained medical personnel may differ in their diagnoses. As such, experts do not recommend using indicators of maternal morbidity as an alternative to maternal mortality as a way to measure the impact of safe motherhood programmes.

### What Can Be Done

■ **Decide whether establishing a national maternal mortality figure is the best use of scarce resources.** If an estimate is needed to stimulate attention and action, decision-makers can use the revised WHO/UNICEF figures to indicate the magnitude of the problem.

■ **Use process indicators to develop, implement and evaluate policies and programmes** based on reliable information. Health planners should be careful to select indicators that are easy to collect and are most relevant to the activities being implemented.

■ **Use findings from maternal mortality studies and programme evaluations widely.** Depending on the type of study, clearly-presented results and recommendations for action may be useful to a broad range of audiences, including: policy-makers, health providers, hospitals, medical societies, community groups, and research institutes. Community involvement can be very helpful both in conducting the studies and identifying and carrying out solutions based on the findings.

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# Unwanted Pregnancy

There are an estimated 200 million pregnancies around the world each year. Approximately one-third of these, or 75 million, are unwanted.<sup>1</sup> These pregnancies contribute to maternal health problems in two ways: first, many pregnancies are unwanted for reasons that can threaten the woman's health or well-being; she may have an existing health problem, or lack the support and resources she needs to have a healthy pregnancy and raise a healthy child. Second, where women do not have access to safe abortion services, many unwanted pregnancies are terminated using unsafe procedures that can lead to the woman's death or disability.

## Unwanted Pregnancy Can Be Deadly

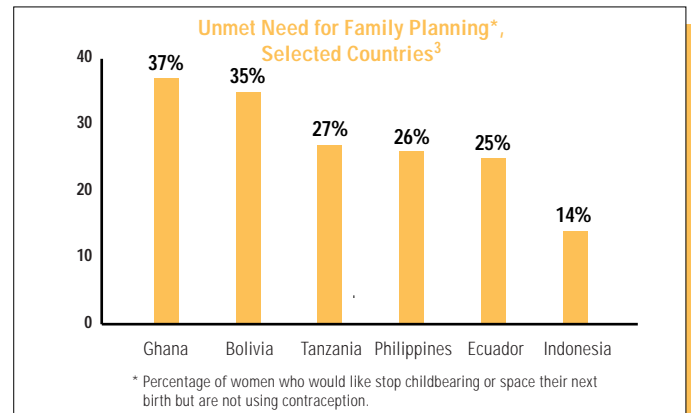
- **Every year, approximately 50 million unwanted pregnancies are terminated. Some 20 million of these abortions are unsafe.** About 95% of unsafe abortions take place in

developing countries, causing the deaths of at least 200 women each day.<sup>2</sup>

## Why Do Unwanted Pregnancies Occur?

- **Although unwanted pregnancy occurs for many reasons, the most common are non-use of contraception or contraceptive failure:**

- *Between 120 and 150 million married women want to stop having children or postpone their next pregnancy, but are not using contraception.* An additional 12 to 15 million unmarried women also want to avoid pregnancy but lack the means to do so.<sup>1</sup>
- *An estimated 8 to 30 million pregnancies each year result from contraceptive failure* — either because the method was used inconsistently or incorrectly, or because the method failed.<sup>4</sup>



## Cultural Traditions Can Limit the Use of Contraception

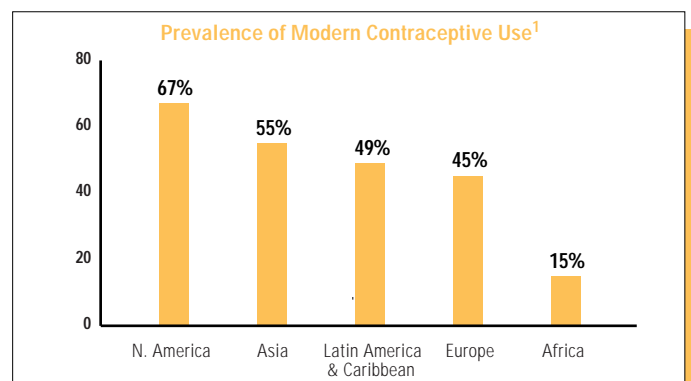
- **In many countries women have little control over sexual relations and contraceptive use.** Social expectations and pressures define what is or is not acceptable for a woman to do, and can make it difficult for a woman to protect herself from unwanted pregnancy:
- *Social taboos and unequal power relations between men and women often prevent women from using contra-*

*ceptives.* Opposition from husbands is one of the most common reasons women give for not using contraception.

- *Between 20% and 50% of women and girls report having been subject to sexual coercion, abuse or rape.*<sup>5</sup> Such women are at high risk for unwanted pregnancy and other sexual and reproductive health problems.

## Contraceptives Are Still Out of Reach

- **Although nearly 60% of women and men around the world use modern contraceptive methods, 350 million couples do not have access to a full range of family planning methods, services and information.**<sup>1</sup>
- **Women do not always know where to get family planning services.** The proportion of married women age 15 to 49 who know where to obtain a modern contraceptive varies widely within regions: from 22% in Mali to 96% in Zimbabwe; from 45% in Pakistan to 99% in Thailand;



from 61% in Bolivia to 98% in Colombia and 99% in Trinidad and Tobago.<sup>3</sup>

- **Use of male contraceptives is low.** In Brazil, condoms and vasectomy account for less than 4% of total contraceptive use<sup>6</sup>. Comparative figures in Iran are 6% for condoms and 1% for vasectomy.<sup>7</sup>

## Inadequate Family Planning Programmes

- **Even where family planning services are available, they may not respond to people's needs and preferences.** In many countries, shortcomings in the quality of family planning programmes include:
  - **A focus on quantitative goals** (such as the percentage of women using a contraceptive method) instead of helping clients achieve their personal goals for the number and timing of their children.<sup>9</sup>
  - **Poor information and counselling.** Studies in sub-Saharan Africa found only 25-54% of new contraceptive users were informed about side effects.<sup>1</sup>

## EMERGENCY CONTRACEPTION

Emergency contraception is a method of preventing pregnancy that can be used after unprotected sex. The most common method is for the woman to take a special dose of oral contraceptive pills, called emergency contraceptive pills (ECPs), within a few hours or days of sexual intercourse. ECPs are not considered a method of abortion. Emergency contraception has the potential to considerably reduce unwanted pregnancy. However, it is not yet widely available in many countries.<sup>8</sup>

- **Promotion of methods that may be inappropriate** for a particular client.<sup>1</sup> This can happen because facilities have limited contraceptive supplies, or because service providers do not spend enough time discussing clients' needs or decide for their clients what methods they should use.
- **Poor clinical skills and procedures**, for example during pelvic exams, sterilisation and IUD insertions, which can cause the client unnecessary pain or infection.<sup>9</sup>
- **Weak or non-existent links to other reproductive health services**, including treatment of STDs, that are needed to preserve a woman's health and future fertility.<sup>9</sup>

## What Can Be Done

- **Governments and donors need to make programmatic changes to:**
  - **Ensure that all individuals** – including adolescents and unmarried women – have access to good quality, confidential family planning services which: offer a full range of methods, including emergency contraception; are responsive to the needs and lifestyles of their clients; and enable women and men to have the number of children they want, while protecting themselves against sexual and reproductive health problems.
  - **Ensure that all providers** of care have the supplies, information, and technical and communication skills necessary for offering high quality care.
  - **Offer reliable information** and compassionate counselling to all women with an unwanted pregnancy, including information about when and where a pregnancy may be legally terminated.\*

**Policy-makers need to address regulatory, social, economic and cultural factors within communities and at the national level to:**

- **Ensure that women have control** over their sexuality and reproduction, rectify power imbalances between men and women, and promote caring, responsible behaviour among men in sexual relations, contraception, pregnancy and childcare.
- **Address sexual coercion** and all forms of sexual violence against women.
- **Address the problem** of unwanted pregnancy among young people, and modify attitudes that stigmatise pregnant girls.

\*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

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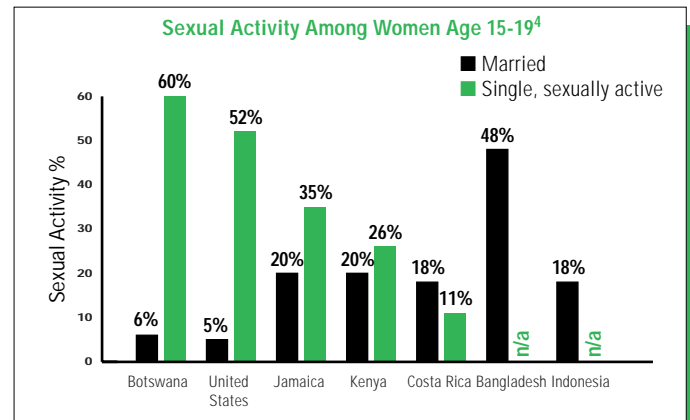


# Adolescent Sexuality and Childbearing

Adolescent pregnancy is alarmingly common in many countries. Every year, adolescents\* give birth to 15 million infants.<sup>1</sup> These young girls face considerable health risks during pregnancy and childbirth. Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties; those under age 15 are five times as likely to die.<sup>2</sup> Because early childbearing is so frequent, and carries so many health risks, pregnancy-related complications are the main cause of death for 15-19 year old girls worldwide.<sup>3</sup>

## Sexual Behaviour and Childbearing

- **Globally, most people become sexually active during adolescence.** Rates are highest in sub-Saharan Africa, where more than half of girls aged 15-19 in seven countries are sexually experienced.<sup>4</sup>
- **Millions of adolescents are bearing children.** In sub-Saharan Africa, more than half of women give birth before age 20. In Latin America and the Caribbean, this figure drops to one third.<sup>5</sup>



## Why Is Adolescent Pregnancy so Common?

- **A lack of information and services:** Adolescents often have poor information about reproduction and sexuality, and little access to family planning and reproductive health services.

*In Sri Lanka, one-third of young adults age 16-24 did not know the duration of a normal pregnancy. Fewer than 5% had discussed reproductive health with their parents.<sup>3</sup>*

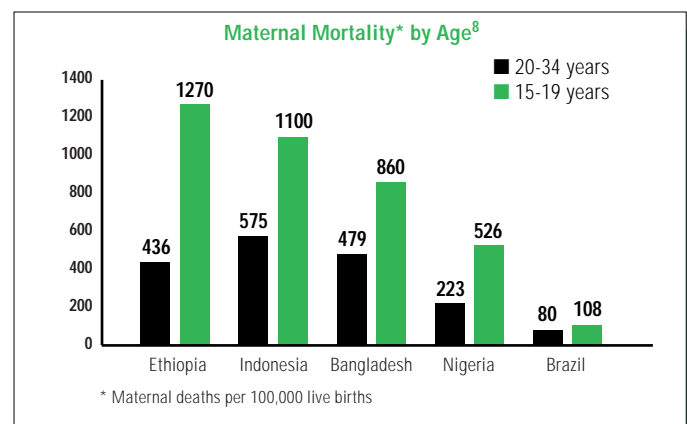
- **Cultural values:** In many developing countries, female status is equated with marriage and motherhood. Adolescents often marry early; more than 50 countries allow marriage at age 16 or below, and seven allow marriage as early as age 12.<sup>6</sup> Even the youngest brides face immediate pressure to prove that they are fertile.<sup>7</sup>

## Health Risks

- **Reproductive health problems and deaths are more common among sexually active adolescents than among women in their 20's and early 30's.<sup>4</sup> Physiologically and socially, adolescents are more vulnerable to:**

- **Maternal death:** Girls age 15-19 are up to twice as likely to die during pregnancy or delivery as women age 20-34.<sup>4</sup>
- **Infant and child mortality:** Children born to adolescents are more likely to die during their first five years of life than those born to women age 20-29.<sup>9</sup>
- **Sexually transmitted diseases (STDs):** Each year, 1 in 20 adolescents worldwide contracts an STD (including HIV/AIDS).<sup>3</sup>

*At Kenyatta Hospital in Nairobi, one-quarter of girls age 15-19 seeking antenatal care had an STD (gonorrhoea, chlamydia or herpes).<sup>10</sup>*



\*The World Health Organization defines adolescence as the period of life between ages 10 and 19.

- **Violence/sexual abuse:** Adolescent girls may lack the confidence and decision-making skills to refuse unwanted sex. Girls who are subject to sexual abuse and rape can suffer serious, life-long physical and emotional consequences.

*In interviews with adolescents in Peru and Colombia, 60% said they had been sexually abused within the previous year.<sup>11</sup>*

## Social and Economic Problems

A young mother's ability to meet her own needs and those of her children can be jeopardised by:

- **A lack of education.** Young women are often expelled from school if they become pregnant, and few ever return.

## Giving Girls Other Opportunities

- **Age at marriage:** Delaying marriage often delays first birth, and can also reduce the total number of children a woman has, since she will spend fewer years in childbearing.<sup>6</sup>

- **Unsafe abortion:** Each year, girls age 15-19 undergo at least five million induced abortions.<sup>12</sup> Because abortion is legally restricted in many countries, adolescents often resort to unsafe procedures by unskilled providers. Adolescent girls therefore suffer a significant — and disproportionate — share of death and disability from unsafe abortion.<sup>130</sup>

*In Kenya, 10,000 girls leave school each year due to pregnancy.<sup>12</sup>*

- **A lack of income.** It can be difficult for young mothers, especially those without education or marketable skills, to support themselves and their families financially.

- **Education:** Women who have some secondary schooling are less likely to give birth during adolescence.<sup>4</sup> On average, women with seven or more years of education marry four years later and have 2.2 fewer children than those with no education.<sup>14</sup>

### What Can Be Done

- **Long-term policies and programmes must address the underlying social, cultural and economic factors that contribute to adolescent sexual activity and childbearing. They must improve the status of women and girls and expand their opportunities by:**

- *Encouraging family and community support* for delayed marriage and childbearing.
- *Expanding girls' access to higher quality education and training*, and helping them build marketable skills.
- *Increasing income-earning abilities*, opportunities to earn income and access to other resources for adolescent girls and women.

- **More immediately, programmes must make it possible for all adolescents to take responsibility for, and protect, their sexual and reproductive health by\*:**

- *Removing legal, regulatory and cultural barriers* to sexual and reproductive health information and services for adolescents.
- *Providing appropriate, accurate sexual and reproductive health education* for young people, both in- and out-of-school.
- *Designing and providing sensitive and confidential reproductive health services* that respond to young people's particular needs; help them make informed decisions about sexuality and negotiate safer sex; and emphasise the prevention of unwanted pregnancy, unsafe abortion and STDs.

\*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

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# Every Pregnancy Faces Risks

Every time a woman is pregnant — which happens an estimated 200 million times every year around the world — she risks a sudden and unpredictable complication that could result in her death or injury, and the death or injury of her infant. At least 40% of all pregnant women will experience some type of complication during their pregnancies. For about 15%, this complication will be potentially life-threatening, and will require immediate obstetric care.<sup>1</sup>

## Which Women Are at Risk?

- **“Maternal risk” is defined as the probability of dying or experiencing a serious complication as the result of pregnancy or childbirth.**<sup>2</sup>
- **Some groups of women are more likely to develop pregnancy complications than others** (for example, if they had a complication during a previous pregnancy). However, it is almost impossible to predict which individual woman will develop a life-threatening complication.<sup>3</sup>

## What Is “Risk Assessment”?

- **Risk assessment is a tool used by health systems that aims to separate women into categories — typically “high risk and “low risk” — according to certain social, demographic or physical characteristics** such as educational status, age, height, and number of pregnancies.<sup>3</sup> Ideally, women who are defined as “high risk” are then given special care to prevent or manage any health problems they may develop. Risk assessment is usually conducted as part of antenatal care during pregnancy.
- **Risk assessment was developed to help health providers allocate their time and resources to the women who need them most**, especially in communities with limited resources. However, a review conducted for the World Health Organization found that risk assessment has not been an effective strategy for preventing maternal death.<sup>4</sup>

## Why Doesn't Risk Assessment Work?

- **The broad characteristics used by most risk assessment systems are not precise enough to predict an individual woman's risk.**<sup>2,5,6</sup> As a result, a large number of women are identified as “high risk”, even though they never develop any complications.

*A study in Zaire found that 90% of women who were identified as “at risk” for obstructed labour ended up not having any problem during delivery.<sup>7</sup>*

- **Most of the women who develop complications do not have any risk factors**, and are therefore classified as “low risk”.

*The same study in Zaire found that 71% of the women who did develop obstructed labour did not have any history of problems.*

- **Even if a woman is correctly identified as being at risk of complications, there is no guarantee that she will get appropriate care.** Many health systems cannot provide adequate services. Also, women themselves may be unable or unwilling to seek medical care when they are told they are “high risk”. They may lack financial resources to pay fees, be too busy, face opposition from family members or simply not want to go.

## When Risk Assessment Fails

- **Women may not receive life-saving care.** Women who are identified as “low risk” can be lulled into a false sense of security. If this happens, they may fail to recognise the signs of complications, and fail to seek appropriate services.<sup>5</sup>
- **Personal cost and inconvenience is high.** Women who are identified as “high risk” may waste valuable time and spend scarce funds seeking unnecessary treatment.
- **Health systems are overburdened:** Misdiagnosing women can create a serious problem for health systems. They may find themselves overloaded and have to spend scarce time and resources on unnecessary treatment for “high risk” women who in fact never develop any complications.<sup>3</sup>
- **Since risk assessment cannot predict which women will experience pregnancy complications, it is critical that all**

women who are pregnant, in labour or recently had a baby have access to high quality maternal health care. This care must include services to manage serious pregnancy complications if and when the need arises.

## What Can Be Done

■ **Governments and health providers need to recognise that every pregnancy is special, and should ensure that all pregnant women have access to high-quality maternal health services by:**

- **Educating women and their families** about the risk of complications faced by all women, and about actions they should take if and when a problem arises.
- **Providing adequate care** as close as possible to where women live. Services should include clean deliveries by health workers who have been trained in midwifery; prompt recognition of complications and appropriate

referrals; and treatment of a woman who is experiencing complications until she can be transferred safely to a higher level of care.

- **Ensuring that a functioning system** of communication and transportation links health workers who are working in communities, health centres and hospitals so that women with pregnancy complications can receive prompt and appropriate medical care.
- **Improving women's overall well-being** and reproductive health through prevention and through screening and treatment for existing problems that contribute to poor reproductive health.

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