Maternal mortality and international agencies

by Deborah Maine

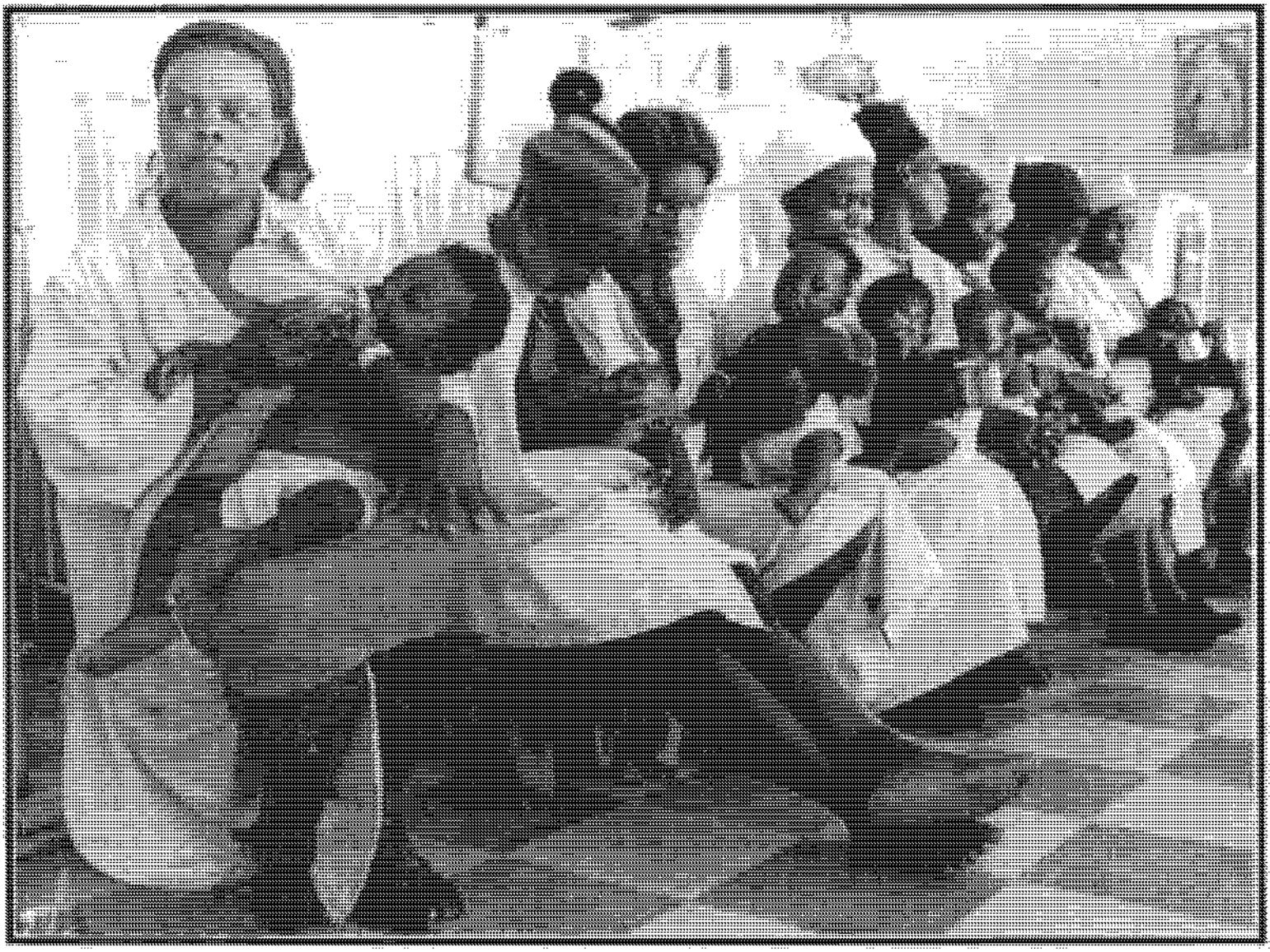
Maternal mortality is one of the highest causes of death among women, particularly young women, throughout Africa. On average, more than 50% of women in sub-Saharan Africa give birth before age 20, and in some African countries as many as 40 % of women have their first child before age 18. Women under 20 suffer more pregnancy and delivery complications, such as premature delivery, prolonged labour, cervical trauma, and death, than do women who bear children at age 20 or later. Factors such as level of education, nutrition, number of pregnancies, advanced age and the physical size of the mother, also contribute to mortality rates. Reliable statistics on the incidence of maternal mortality in South Africa are, however, hard to find, particularly regarding the incidence of maternal mortality amongst black women.

This article looks at the incidence of maternal mortality in Africa and argues that international agencies have neglected maternal mortality in their funding of health care. Part of the reason for this, the article argues, is that maternal health has been lumped together with child health in maternal and child health (MCH) programs. In these programs infant mortality has been the focus of attention while maternal mortality has been almost entirely neglected. The author suggests that sexism has been one of the reasons for this neglect. It also raises the question of what kind of approaches will be effective in dealing with maternal mortality.

Maternal mortality is the leading cause of death among young women in many poor countries. Although relatively few adequate studies have been done in underdeveloped countries, those that exist clearly show the seriousness of the problem.

In many African countries, more than one out of every 200 women who gives birth dies as a result. By comparison, in the United States the figure is about one out of 8 000. This discrepancy between developed and underdeveloped countries is much larger than that for infant mortality.

Furthermore, a woman's risk of dying accumulates with each pregnancy. Consequently, her lifetime risk of maternal death may easily be one in 30. This means that unless something is done, we can look at a group of young African women and know that



Maternal health care has largely been neglected in health care programmes

one in 30 will die of a pregnancy related problem in the prime of life. The worst part is that we have for decades possessed the ability to prevent almost all maternal deaths.

Recently, there has been a surge of interest in maternal mortality. In February 1990, the First International Conference on Safe Motherhood (the Safe Motherhood Initiative) was held in Nairobi. Subsequently, virtually every international agency and foundation is getting involved in programmes to prevent maternal deaths.

I will review some aspects of the former inattention to this problem and discuss some of the challenges of the new era.

The years of neglect.

Women and children are a key concern of any health care system. In many developing countries, women of reproductive age and children comprise about two-thirds of the total population. Furthermore, women are responsible for bearing and raising the next generation. Therefore, it makes sense to pay particular attention to their well-being.

Indeed the World Health Organisation estimates that more than half of all resources devoted to primary health care are allocated to maternal and child health ("MCH") programs.

Many people assume that women's health has been receiving a substantial proportion of the available health resources, and that helping women survive pregnancy and delivery has been a high priority. Unfortunately, this is not the case. For decades, maternal mortality has been neglected in both health programmes and research.

The sad fact is that there is little in the conventional MCH package that can reduce maternal mortality. The common components of MCH programs today are: immunization of young children to prevent measles and other infectious diseases; teaching mothers to perform oral rehydration of infants with diarrhoea; weighing of young children to monitor their growth; encouraging women to breastfeed for the sake of their children's health; and immunizing pregnant women against tetanus so that they can pass the antibodies on to the foetus. While all these activities involve women in one way or another, women are not the direct beneficiaries of any of them (although tetanus immunization may incidentally prevent a tiny proportion of maternal deaths).

Other components of MCH programs are food supplementation, antenatal screening, and family planning. The costs and benefits of antenatal screening are too complex to discuss here. Suffice to say that when antenatal screening for women at high risk of complication is carefully studied, either in developed or underdeveloped countries, its potential to substantially lower maternal mortality is dubious.

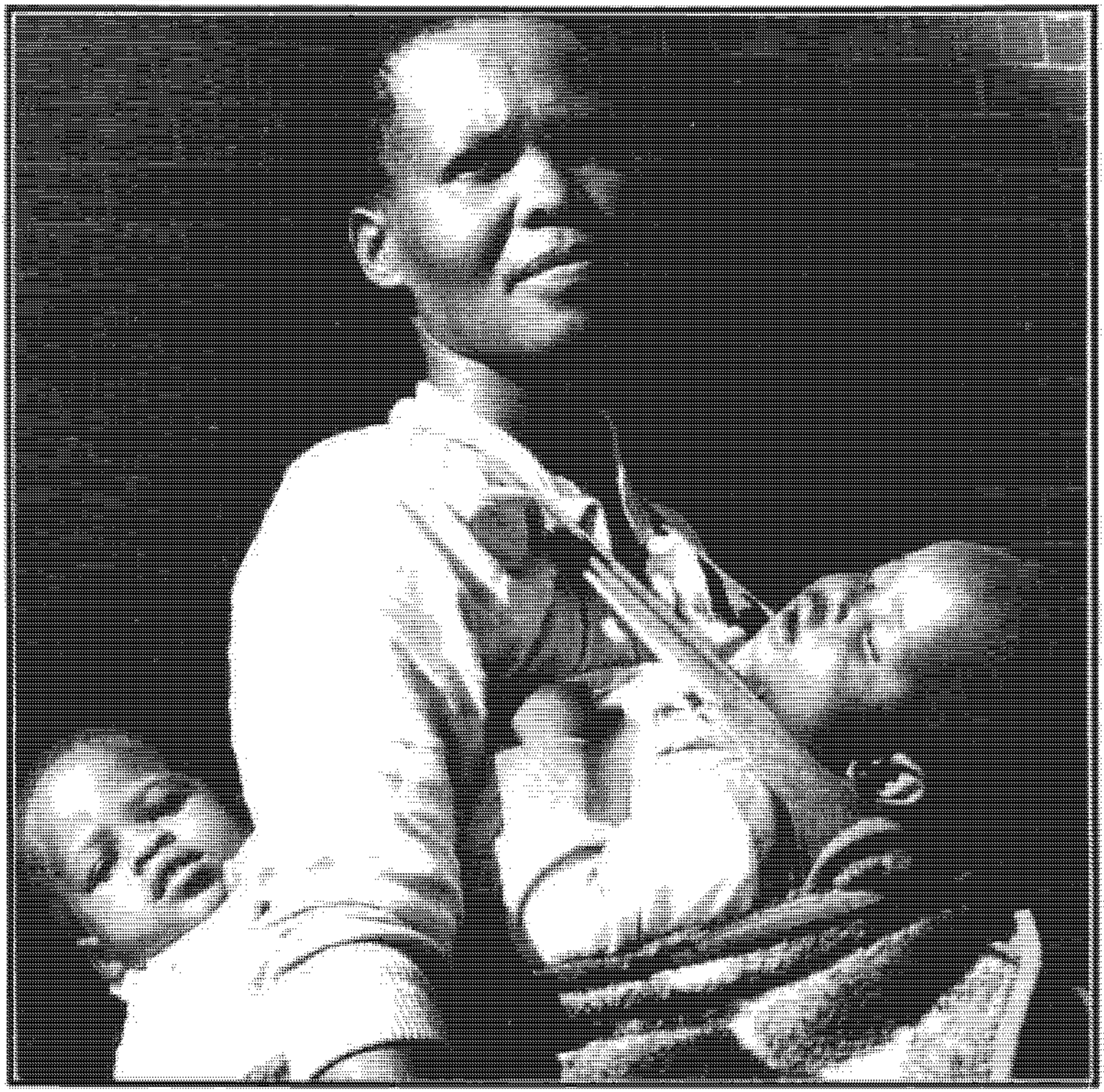
Preventing maternal deaths

Of all the activities listed so far, the one that has the greatest potential to prevent maternal deaths is family planning. If only women who say they want no more children had no further pregnancies, I estimate that maternal deaths in sub-Saharan Africa would be immediately reduced by nearly one-sixth.

Once they become pregnant, however, women must have access to medical care if maternal deaths are to be prevented. Even in industrialised countries, a certain proportion of pregnant women (perhaps 15%) will develop serious complications. Without banked blood for resuscitation in haemorrhage, antibiotics to treat infection and caesarean section to relieve obstructed labour, many such women will die.

Neglect of maternal mortality

The neglect of research into maternal mortality became obvious to me through the process of writing two articles on the relationship of family planning to MCH - one in 1980 and the other, five years later. Going back to this literature I was struck by the



More research and resources are necessary to lower maternal mortality rates.

contrast between the tremendous progress made in our understanding of infant mortality in developing countries, and the paucity of new data or writing on maternal mortality.

Of course, there are lots of health issues that need more attention and more research. The difference with maternal mortality is that the neglect is disguised by the apparently encompassing title "maternal and child health." Because MCH programmes comprise such a large part of primary health care activity, and because women are the recipients of some of these services (even though the beneficiary is the foetus or child), it appears that women are being cared for and receiving a relatively large share of the health resources.

Why the neglect?

There are probably many reasons why maternal mortality received so little attention in the past. I will consider only a few.

In some recent articles on maternal mortality, it is implied that the reason that there is such a surge of interest in this topic is that the international health community has only recently learned the extent and severity of the problem. I think of this as the "we didn't know" excuse. It just is not true. For example, well over a decade ago the results of one of the best maternal mortality studies ever done were published. This study, in the Matlab area of Bangladesh, showed that maternal mortality rates were extremely high, and in fact raised the death rate for young females above that for males.

Another possible reason for the neglect of this issue may be that maternal mortality had declined drastically in the west by the end of World War II, when international assistance became a major force in health systems in the underdeveloped countries. At the local, as opposed to the international level, fatalism may have been a factor - women have always died in childbirth - the thinking may go, that they always will.

Sexism as a reason for the neglect

What about sexism as a reason for neglecting the issue of maternal mortality? By now feminists may have recognised in my description of the situation a pattern that is found in many areas of life, not just in international health: women's well-being has been subsumed into and subordinated to that of other family members - in this case, their children. Is it paranoid to suspect that the neglect of maternal mortality is just one more manifestation of systematic disregard of women?

Consider for a moment a curious feature of recent articles on maternal mortality. The great majority of these articles start with some statistics demonstrating the size of the problem (such as the number of maternal deaths that occur annually). So far so good. However, the second sentence in the article usually states that maternal mortality is important not only because women die, but because their death often leads to the dissolution of the family and a serious reduction in the likelihood that their children will live to adulthood.

While these consequences of maternal death are indeed important, it appears that the authors feel a need to justify their concern for maternal health on some basis of wider, societal good, as though the fact that women are dying unnecessarily is not sufficient grounds for concern and action. Certainly, maternal deaths have wide significance. For example, from the point of view of society's investment in an individual, the death of a women in the prime of life is a much greater loss than is the death of an infant. Yet there seems to be no comparable need to justify actions to prevent infant deaths.

Challenges of the future.

The corollary to the question of why was maternal mortality a neglected issue is: why is there all this interest all of a sudden? To this question I have no good answer.

Nevertheless, for those who have bemoaned the lack of attention to maternal mortality, the recent rush of interest and funds is very welcome. However, there are pitfalls ahead. One of them is that every agency is eager to have a maternal mortality programme, but there are still major questions to be answered as to what approaches will be effective in preventing maternal deaths in developing countries.

For example, the response of the U.S. Agency for International Development (AID) to the Safe Motherhood Initiative was to call for proposals on ways to spend funds on nutrition for Safe Motherhood. The scientific underpinnings for such an approach are unclear. While anaemia among pregnant women in underdeveloped countries is a common problem, I know of no evidence that giving women supplemental food during pregnancy will reduce deaths from the common causes of maternal deaths. In fact, it seems just as plausible to me that this kind of programme might increase rather than decrease the number of maternal deaths, since small women might start having larger babies.

Careful evaluation needed

Of course, there will be false starts in any new initiative. Agencies and health services may just continue doing variations on the same old MCH programs, hoping that if they do them more and better, somehow maternal deaths will be prevented.

What is needed is to think critically about the programme options, and then to carefully evaluate their effects and costs. Given the fads in international funding, there isn't very much time in which to do this. Perhaps we have five years, maybe as long as ten, to develop effective, efficient ways to prevent maternal deaths within the context of existing health systems in developing countries. If we do not succeed, maternal mortality will join the dozens of other health problems that had a short period of attention and increased funding, but then sank back into obscurity.

Deborah Maine is Program Director at the Maternal Mortality Prevention Program, Columbia University, New York, USA.

Women & AIDS: An International Handbook
Edited by: Marge Berer
Projected publication date: September 1982

A CALL FOR INFORMATION AND MATERIAL

You are invited to become involved in preparing an international handbook on women & AIDS. The handbook will be for women, women's groups and organisations, NGOs and other agencies.

The handbook will contain information on: patterns of infection among women in different regions; how women get and transmit HIV and how this can be prevented; HIV and other sexually transmitted diseases; counseling and testing of women for HIV infection; the consequences for women's sexual lives and relationships; HIV and pregnancy, birth control and abortion; women's roles as carers for themselves and others with HIV/AIDS, as health care workers and as sex workers; the many education, support, self-help, counseling and training programmes and services that exist for women; discrimination against women with HIV; and what agencies, networks and resources there are for women internationally.

Contributions of existing and original material for the handbook are welcome - personal experiences; leaflets, pamphlets, books, papers; cartoons and posters; transcripts of interviews, and discussion sessions; training and educational materials; guidelines for women and health care workers; descriptions of groups, resources, networks and training programmes; laws and policies affecting wome...

For further details and to contribute material, contact: Marge Berer, PO Box 16801, 1001 RH Amsterdam, Netherlands, tel. (31-20) 235005.

SECTION B

WOMEN & AIDS

A person who wishes to reduce his or her chances of contracting AIDS may practice "safe sex". However, if one's sexual partner refuses to practice "safe sex", it may be difficult for one to avoid contracting the disease. In many relationships between men and women, women find themselves in a subordinate position. Because of this they may find it difficult to insist that their partners follow "safe sex" practices. This problem is one of many which are focussed on in the articles in this section.