Why are mothers still losing their lives in the process of pregnancy and childbirth?
HOW MUCH ARE MOTHERS WORTH?

- WHY ARE MOTHERS STILL LOSING THEIR LIVES IN THE PROCESS OF PREGNANCY AND CHILDBIRTH?

The World Health Organization estimates that every year about 500,000 women lose their lives in the process of pregnancy and childbirth. They do not die from causes which we do not know or which we cannot prevent or treat. The know-how is already available to prevent and/or effectively manage the potential maternity-related life-threatening complications. Nor do these women die because of general lack of resources that can be tapped to provide the necessary health care interventions. It is true that 99% of maternal deaths occur in developing countries. However, the high levels of maternal mortality cannot be considered a direct outcome of poor socio-economic development. For one reason, levels of maternal mortality vary widely between countries with the same economic level and several developing countries with a low or lower middle income economy have brought down their maternal mortality rates to low levels.
Countries having the same level of low per capita income can have widely different levels of maternal mortality. At a low per capita income of $250-350, maternal mortality is much lower in Vietnam (Maternal mortality ratio MMR 160) than in Yemen (MMR 1400) [1]. At the higher but still low level of $690 to 950, the level in Sri Lanka (140) cannot be compared with that in Bolivia (650) or Cote d’Ivoire (810).

It should also be noted that socio-economic development per se, without the availability and utilization of health care, will not make motherhood much safer. A study conducted in the United States compared maternal and perinatal mortality rates among women who were members of a religious group in Indiana and who avoided obstetric care, with the statewide rates. Members of the religious group had a perinatal mortality rate three times higher and a maternal mortality rate about 100 times higher.
The tragedy of maternal deaths in the world today is an issue of priorities in the allocation of resources. It is a question of how much mothers are considered worth.

What is the monetary value of a woman’s life?

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Rational allocation of resources to prevent deaths requires, according to
This notion may be repugnant to the medical profession who likes to think that nothing is too expensive for the sake of saving life. However, societies unconsciously or consciously, put such values in their decision making process. One element in the valuation of a human life is how much investment society has made in the individual. Another element is the productivity factor. Sir William Petty, as far back as 1699, advanced a method of valuation that was based on the assumption that an individual contributes to society his production, which is equivalent to his earnings. This earnings-estimate, adjusted to expectation of working life, provides a commonly utilized means for calculating the value of human life.

The value system underlying judgment about the monetary value of human life is not simply a question of economics. It is also a question of social ethics, particularly where women are concerned. Many societies in developing countries tend to invest less in girls than in boys and to underestimate the economic contribution of women. Gender comparisons in 112 developing countries show that rates for women, compared to men, were 74% for adult literacy, 57% for enrollment in higher education and 49% for labour force participation. A common belief is that women contribute a minor share of the world's economic product. Conventional measures of economic activity
undercount women's paid labour and do not cover their unpaid labour. It has been estimated that the value of women's work in the household alone, if given economic value, would add an estimated one-third to the gross national product.5

Apart from these social perceptions of a woman's worth, there are medical indicators as well. In many countries, sex differentials exist in infant and child mortality 6. Another medical indicator of concern is the abuse of prenatal sex determination for selective abortion of the female foetus.

**Is maternity a disease or a duty?**

A rational allocation of resources in the health sector demands the ranking of diseases at different levels of priority. This can be done through a rough indicator of a "body count" or in a more refined way by using a criterion such as quality-adjusted life years (QALYs) gained.7

Maternal causes account for 1.3 percent of all deaths in developing countries.8 If maternity is ranked as just another disease, its ranking will not be high from an epidemiological approach. The question, however, should be raised as to whether society would be right to rank maternal health problems with other diseases. Maternity is a social function. Maternity-related diseases and injuries are incurred during performance of this social function. Society has more of an obligation for preventing maternal deaths than for preventing deaths from other diseases.
Resources allocated for maternal health are generally lumped together with resources for child health in an MCH package.

It is true that maternal health interventions also benefit the child. An expectant mother with no prenatal care, for example, is three times more likely to have a low birth-weight baby. However, to save mothers' lives, certain relatively high cost interventions are needed, and may have less impact on perinatal mortality.

The "M" in MCH has often been seen as a means and not an end, as a means for child health. Interventions such as nutrition and prenatal care are often justified on the basis of the benefit to the child. Even strategies for mothers' survival are being justified as necessary for child survival. Studies have been designed to show that infant mortality increased only slightly after the father's death but increased dramatically with the mother's death, particularly for a female child.

The Plan of Action for implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s tried to address this issue by stating that "Maternal health, nutrition and education are important for the survival and well-being of women in their own right and are key determinants of the health and well-being of the child in early infancy."
Where is safe motherhood in primary health care?

Since the Alma Ata international conference on primary health care in 1978, more and more countries are shifting resources for primary health care. Recently, 81 Member States provided information to WHO on the proportion of national health expenditure devoted to primary health care. Among these, 19 reported a proportion of 50% or more. The average of these proportions for all Member States was about 35%, with 41% for the least developed, 34% for the developing and 31% for the industrialized countries. From the available data, WHO concluded that though the percentage of GNP spent on health has been stationary since the 1985 evaluation of health for all strategies, the proportion devoted to primary health care has increased markedly.

The emphasis in primary health care is on low cost interventions that potentially benefit large numbers of people. In the context of maternal health, these relatively low cost interventions include community-based prenatal services, training of traditional birth attendants and provision of family planning services. In spite of all the health benefits of these interventions, they are less effective in reducing maternal deaths. A recent study has estimated that two-thirds of maternal deaths can only be prevented through the provision of essential obstetric functions at the first referral level. Family planning can prevent up to a quarter of maternal deaths, depending on the prevalence of unwanted pregnancies and the availability or lack of safe pregnancy termination services. Community-based prenatal care and delivery by trained
birth attendants, if not backed up by an effective referral system, will only prevent up to 10 to 15 percent of all maternal deaths.

**Who shall live? Who shall die? Who shall decide?**

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When resources are limited, decisions have to be made, tough decisions, on who shall live and who shall die. Decision-makers generally act on their own judgment as to what benefit they themselves or the society at large could derive from a choice among competing health interventions. The benefits are both those assessed scientifically as well as those perceived subjectively. Women are a minority among decision makers. Although they comprise 50 percent of the world's enfranchised population, women hold no more than 10 percent of the seats in national legislatures; in one government in three there are no women in the highest decision-making body of the country, and in those cabinets where women are included, there is usually only one woman.

**Conclusion**
CONCLUSION

Adequate allocation of resources to address the tragedy of maternal mortality will be possible:
- if women are valued more in their societies,
- if maternity is recognized as a social duty for which society has an obligation,
- if resource allocation to maternal health is identified within the MCH package,
- if the concept of primary health care is extended to cover essential obstetric functions at the first referral level, and
- if more women are involved in the national decision-making process.

REFERENCES


