

On Women's Health and Rights
Lectures, Speeches and Statements
Mahmoud F. Fathalla

Why did Mrs X die?

Launch of the Safe Motherhood Movement

International Conference on Safe Motherhood

Nairobi, 1987

In this presentation, I want to share with you the human side of the story of the tragedy of maternal deaths in developing countries. Let us look at a typical profile for one of those unfortunate half a million mothers who die every year

Mrs X died during labour. This is not an unusual event. There is a Mrs X dying because of pregnancy and childbirth every minute somewhere in the developing world. What is an "unusual" event is that the world has begun to ask questions about it.

Mrs X died in a small district hospital. The physician in charge had no doubts about the diagnosis. It was a straightforward clinical case of antepartum haemorrhage due to placenta praevia- the placenta was implanted low down in the uterus. A patient with the condition will inevitably develop haemorrhage during pregnancy and/ or during labour. The doctor looked up the International Classification of Diseases (ICD), coded the cause of death as ICD 641.1.1.: Haemorrhage from Placenta Praevia, and closed the file.

But the hospital has a Committee for Confidential Inquiries in the Causes of Maternal Mortality, following the system recommended by the International Federation of Gynaecology and Obstetrics. The Committee looked in detail at the hospital record of Mrs X. When she was admitted to hospital in a state of shock because of severe bleeding, she received intravenous fluids. Only one-half litre of blood transfusion could be made available, which was not enough to compensate for her blood loss. A Caesarean section was performed three hours after admission, when a specialist obstetrician and an anaesthetist could be summoned. She died during the operation. The Committee concluded by classifying the cause of death as "avoidable", due to a defect in the service. The Committee argued that if blood transfusion had been more freely available and if the service was better prepared to handle emergencies, the life of Mrs X could have been saved. On this note, the file was closed.

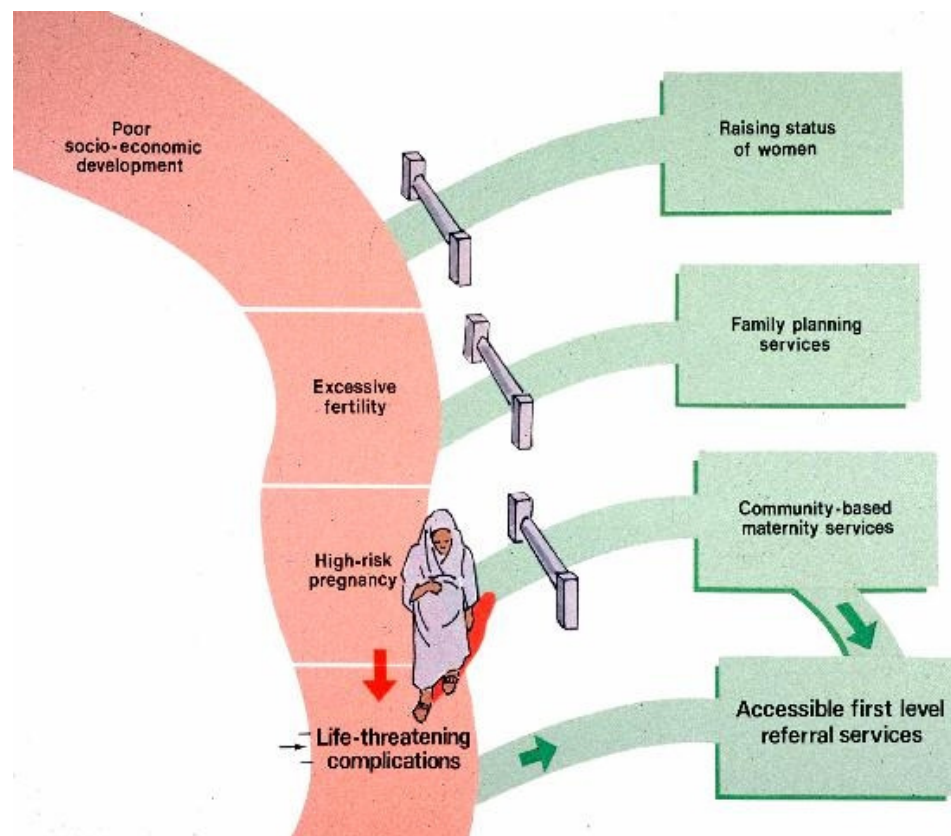
A WHO-supported community-based study was being conducted in the area, looking into "Unmet Needs in Maternity Health Care". The study unraveled more data about the circumstances of the death of Mrs X. It took her four hours to reach hospital after the onset of bleeding. This attack of bleeding was not the first. She had two minor episodes of bleeding in her last month of pregnancy, the serious significance of which was not heeded. She was also suffering from chronic iron deficiency anaemia because of parasitic infestation and she never had any antenatal care. The study concluded that the cause of death was unquestionably the unmet need in community-based maternity

services. If emergency transport was available or if she had access to antenatal maternity care to treat her severe anaemia and to refer her when she had the minor episodes of bleeding, her life could have been saved.

Another study, supported by Family Health International, was looking into the causes of reproductive age mortality, and unraveled yet more facts about the death of Mrs X. The study reported that she was aged 39; she had given birth to seven children of which five were still alive. Three of them were boys. She did not really want any more children, and her pregnancy, ill-timed in terms of age and parity, carried a much higher risk than usual. She had never used any family planning method. The study concluded that the cause of death of Mrs X was the lack of access to family planning information and acceptable services. She would not have died if she did not get pregnant in the first place.

The Population Council was supporting a study on socio-economic differentials in mortality when the case came under scrutiny, and yet more information was supplied. Mrs X was the illiterate wife of a poor agricultural labourer. The study concluded that her socio-economic status put her at risk of maternal death, three times more than the average for the country, 10 times more than the risk in the highest socio-economic group, and 100 times more than the risk in the nearest developed country.

It is clear from the story of Mrs X that there are different perspectives in looking at the causes of maternal death. But are these perspectives really different or are they part of an overall gloomy picture? To answer this, let us retrace this mother's steps along the "Maternal Death Road".



Mrs X found herself at the entrance to the "Maternal Death Road" by the socio-

economic condition of the community in which she lived and by her status within that community. Poor socio-economic conditions can account for a mortality differential, even in developed countries. However, this is not what is making maternal mortality the world tragedy that it is today. In fact, maternal mortality is a much less sensitive indicator of socio-economic conditions than infant and child mortality.

The status of women in the society makes more of a difference. When women are denied their rightful status, they become more socially disadvantaged - the poorest of the poor. As a child, she will be denied whatever education her brother will have. She will be the last to feed from the limited family pot. She will not receive the same level of care in case of illness. These would be the woman's first steps along the maternal death road.

For Mrs X, not only was the level of development poor, but she did not have a fair share of the outcome of whatever economic growth was gained. She could have been given the chance of taking a safety exit, if she had equal access to education, employment, and better nutrition-if she had not been discriminated against as a woman.

Mrs X found herself moving downhill and excessive fertility was her next stop. Her next steps would lead her into a society-imposed excessive fertility. It was her only acknowledged contribution to society. Children were the only goods she could deliver, and her status as a woman depended on her role as a mother. Each time she got pregnant, Mrs X faced the risk of being pushed further along the road, and her cumulative risk increased.

Her pregnancies will be too early, too close, too many and will continue for too late. Her reproductive life is governed by chance and not by choice. Even if she wanted to take control, access will be denied.

If women who wanted no more children were allowed to do so, maternal mortality in many countries would be decreased by about one third.

Even if she felt trapped into a really unwanted pregnancy, the pleasure of the society will be to see her join the tens of thousands women who sacrifice their lives in their attempt to escape.

Moreover, excessive fertility meant that reproduction continued beyond the limits of safe childbearing. She continued on her reproductive career beyond the age of 35 and beyond the fourth child. She could still have been allowed a way out of the Maternity Death Road if she had access to family planning information and services to stop child-bearing when she no longer needed or wanted another child. But Mrs X was never given that chance.

Her next stop is when she develops a high risk pregnancy or life-threatening complications. Prejudice will deny her access to community-based services with access to first level referral services. Because of her age and parity, added to her socio-economic status, her pregnancies now came under the obstetric category of "high-risk". She became more liable to develop serious complications during pregnancy and childbirth. There was still a safety exit. If she had access to simple but efficient

community-based maternity health services, her severe anaemia would have been corrected, the ominous significance of her repeated minor episodes of bleeding would have been recognized, her high-risk category would have been diagnosed and she would have been referred to the facility where she could have been taken care of.

When, finally, she developed a life-threatening complication, antepartum haemorrhage, there was one last chance for a way out: an accessible and effective first referral service. But it was neither readily accessible nor that effective. She lost her last chance.

The death of Mrs X teaches several lessons that could help to rescue the millions now moving along the road to maternal death. This case illustrates the concept that maternal deaths in developing countries should not be looked upon from a narrow medical perspective, as the result of isolated disease episodes. Maternal mortality is commonly the last stop in what we may metaphorically call "THE ROAD TO MATERNAL DEATH"

This road is easily accessible at a number of points along its treacherous course, starting with poor socioeconomic development, excessive fertility, high-risk pregnancy, and finally the well-known life-threatening complications. Its exits or safety turnings start with better status for women (including nutrition, education and gainful employment). then family planning information and services, community-based maternity services and first-level obstetric services.

In developed countries, the numbers of women who step on the road are few; they usually join nearer the end of the road, and will soon find an exit out. In developing countries, the numbers are enormous, women usually join nearer the beginning of the road and continue moving on, and a way out is not readily available.

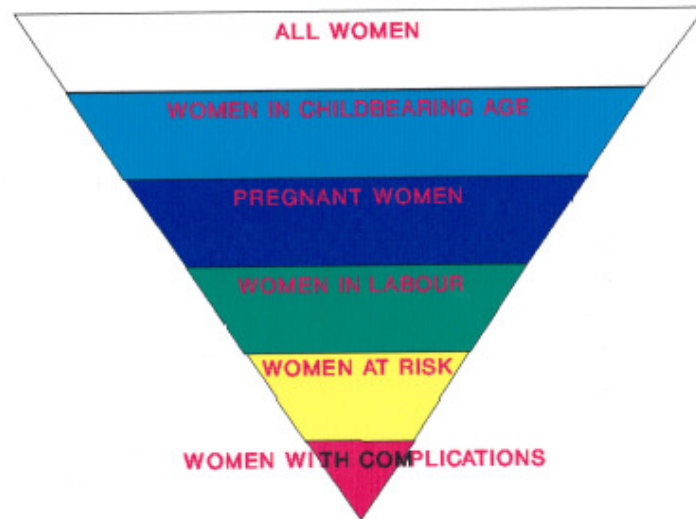
The improvement of socio-economic conditions is a long-term goal. Putting the brakes to excessive fertility is still a long way ahead. High-risk pregnancy, whether the risk factor antedates the pregnancy or develops during pregnancy, cannot be completely prevented. The major life-threatening complications of pregnancy and childbirth-haemorrhage, toxæmia, sepsis, obstructed labour and abortion- are not always predictable.

However, the dangers can be limited if the safety exits are used effectively. Thus, socio-economic interventions to raise the status of women will reduce the numbers of those who reach the stage of excessive fertility. Access to family planning services will reduce the numbers who reach the high-risk pregnancy point. Early detection and management of high-risk pregnancy will reduce the numbers who reach the point of life-threatening complications.

Since the majority of women in developing countries who join the road to maternal death do so early and near its beginning, all the safety exits have to be widened. The more the early exits can be widened, the less pressure there will be on the later ones. If family planning services are not properly expanded, then the load on the next exit, community-based maternity services will be more. If community-based maternity services are not adequate, the load on the first level referral service will be proportionally increased.

Understanding of the concept of the maternal death road is essential for developing a comprehensive strategy for mother's survival. .

Elements of a strategy for mothers survival



A comprehensive and integrated strategy for mothers survival should have the following basic elements to address the maternal health needs of all women, all women in the reproductive age period, all pregnant women, all women in labour, women with high risk pregnancy, and women with obstetric life-threatening complications:

Advancement of the status of women:
for all women

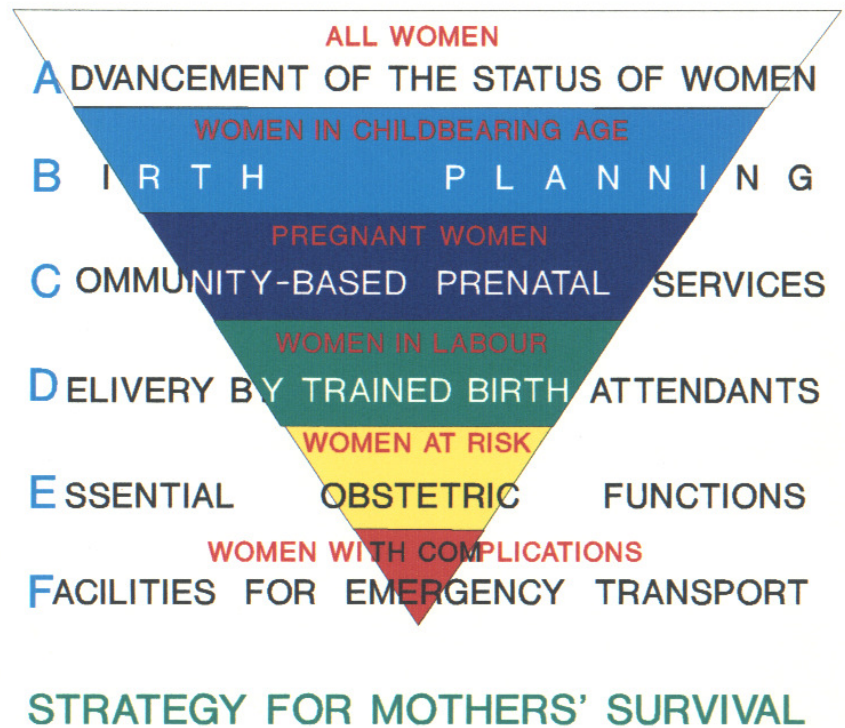
Birth planning:
for all women in the reproductive age period

Community-based prenatal services;
for all pregnant women

Delivery by a trained birth attendant:
for all women in labour

Essential obstetric functions:
for women with high risk pregnancy

Facilities for emergency transport:
for women with obstetric life-threatening complications



The six basic elements of the strategy should be considered a package of interrelated elements, and not as different options. The potential impact of each element is in fact partly dependent on the presence of the other elements. Advancement of the status of women and birth planning have a two-way relationship. Without birth planning, maternity services will be over-burdened by the large numbers of unwanted pregnancy, induced abortions, and high-risk pregnancies. Without community-based prenatal services and delivery trained birth attendants, cases at high-risk and life-threatening complications will not be detected at an early stage to allow their successful management at the first referral level. It is important to realize that without the backup of essential obstetric functions at the first referral level and the facilities for emergency transport, community-based services by trained personnel will not be effective in ensuring safe motherhood.

(A video-tape with the author's title of "Why did Mrs X die?" is available in English, French, Spanish and Arabic from the World Health Organization. Video "Why did Mrs X die-retold" was produced by HANDS ON for mothers and babies, and is available from the FIGO website).