

On Women's Health and Rights
Lectures, Speeches and Statements
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The road to maternal death in developing countries

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It is most gratifying for me, an obstetrician from the third world, to see this distinguished gathering in the capital of the world discussing a major tragedy of our time: the tragedy of maternal mortality. It is most gratifying because maternal death is not a U.S. public health problem. Most obstetricians in this country would end their professional career without having to witness such a tragic event. For someone like me, maternal mortality is not words, is not figures and is not statistics. It is women who have names. It is human faces seen in awful suffering and despair, faces that live forever in your memory and continue to haunt your dreams. It is to be witness to a tragedy that bears heavily, too heavily, on your morality and your conscience.

In this short presentation, I want to share with you the human side of the story. The message that I would like first to get through to you is that maternal mortality in the South of our world is a different story from the maternal mortality which you may rarely encounter in the North.

The first difference is one of magnitude. Maternal mortality rates, or to be more correct, ratios, for women in developed countries, range from 5 to 30; for women in developing countries the range is from 50 to 800. Maternal mortality ratios show greater disparity between countries than any other public health indicator. This should tell us something.

The inequity is even more dramatic if we look at the lifetime risk of maternal death. For a woman in Africa, it is 1 in 21. For her sister in North America, it is 1 in more than 6,000. In Northern Europe, it is 1 in almost 10,000.

The tragedy is that women go through it knowing what they are facing. In a piece of Tanzanian folklore, a woman about to give birth tells her older children "I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return."

The difference in maternal mortality between the rich and the poor is not only

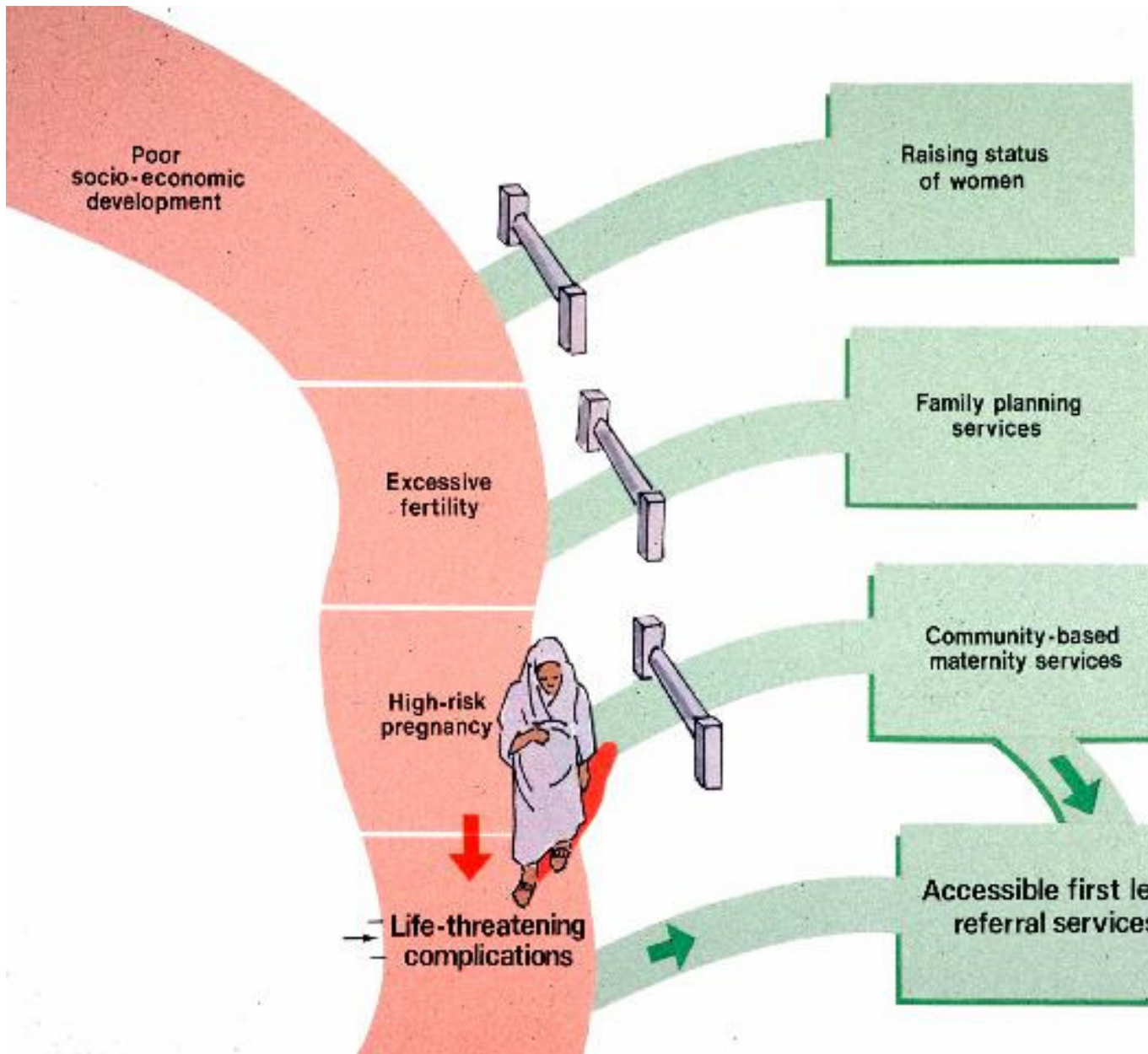
a difference in magnitude. It is also a difference in the way to die.

In the U.S. today, the commonest cause of maternal mortality is pulmonary embolism, a more civilized way to die.

In developing countries, the most common causes of maternal deaths are haemorrhage, infection, toxæmia, obstructed labour and induced abortion. These medical technical terms do not convey the human suffering behind them. I cannot think of a more terrible way to die than a maternal death as it occurs in the developing world today. Imagine the poor woman in the process of giving life, when she consciously sees and feels the huge gushes of blood rapidly draining life out of her body. Think of the woman who gave birth and instead of the blissful joy of maternity, her body succumbs to the invading microbes until death relieves her suffering. Think of the face contorted by pain and the body in the agony of convulsions in eclamptic toxæmia. Imagine the complete helplessness of the woman in obstructed labour with her body taken over by the distressful awfully strong uterine contractions exhausting her completely to a fatal end. Then consider those women who have to risk and often sacrifice their lives because of a pregnancy they did not want and they cannot cope with. And beware that a majority of these deaths are taking place in the absence of any medical help. If I were a woman in the third world, I think I would pray to God to give me any death except a maternal death.

The third difference that I would like to emphasize is that the 1% of the world total of maternal deaths that take place in developed countries may represent a medical problem pure and simple, while the 99% which take place in developing countries cannot be simply looked upon as just another medical problem. They represent the ultimate manifestation of social injustice and discrimination against women.

Let us look at a typical profile for one of those unfortunate half a million mothers who die every year.



The story begins with her being a woman born and living in a poor socio-economic environment.

Poor socio-economic conditions can account for a mortality differential. It does even in the U.S. if one compares maternal mortality between black and white, and between the married and unmarried. 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 family pot. She will not receive the same level of care in case of illness. That would be the woman's first steps along the maternal death road.

Her next steps would lead her into a society-imposed excessive fertility. Children are the only goods society expects her to deliver. Her pregnancies will be too early, too close, too many and will continue for too late. Her reproductive life is governed by fate 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 200,000 women who sacrifice their lives in their attempt to escape.

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.

Why are these services sadly lacking in the developing world? The answer is simple. The woman in the mother has been left out, and has been neglected. We targeted the health services to mothers to help them to produce healthy babies. We forgot that there is a woman in the mother, who also has a right to life.

If you ask why should maternal mortality, as a public health indicator, show the widest disparity between the North and South, although pregnancy and childbirth carry the same inherent biological hazards everywhere, I would give two reasons and both reasons are very sad. The first is that the woman from the South goes through the journey of pregnancy and childbirth burdened with a heavy luggage of social injustice, which she accumulated as a girl, as a woman with no control on her fertility, and as a mother whose interests as a woman are secondary to the interests of her foetus.

The second reason is that, with the available know-how, maternal death is a condition we can prevent or reduce to a minimum. This country did it in only a few decades. Within two decades only, maternal mortality was decreased ten times. With the next two decades, it was decreased again four times. We now have even a better know-how than a few decades ago. When WHO sets a target to decrease maternal mortality by 50 percent in this decade this should not be an unrealistic target.

This is the human side of the story of maternal mortality, the sad story about women who find themselves, through social injustice, on a slippery maternal death road and are denied exit. This great country raised the motto "Live free or die". For your sisters in the South, this choice is a luxury they cannot afford. They do not live free and they die.

If we do nothing about it, the world Daily Reproductive Health News will continue to have the headline of the death toll in human reproduction and 1370 mothers reported killed in physiological duty, with thousands more, seriously injured.

GLOBAL VILLAGE

DAILY REPRODUCTIVE HEALTH NEWS

DEATH TOLL IN HUMAN REPRODUCTION

1370 women reported killed during physiological duty; thousands more, seriously injured.

If we decide to do something about it, we have two options. We may look upon maternal mortality as just another health problem. We rank it in relation to other health problems by body count or by years of healthy life lost. We look closely at costs and benefits. If that is our option, then let us tell those thousands of mothers struggling for their life at this very hour: Sorry, this is not your day.

If, on the other hand, we see the tragedy of maternal deaths for what it is, another ugly holocaust, a slaughter of women, the final blow in an incessant drama of inequity and social injustice, then let us say it will not stand, and let us work at all cost to put this tragedy where it belongs, in the disgraceful trash of the history of humanity together with slavery, racism, apartheid and the like.

There will always be among us those who do not want to see, who do not want to hear and who do not care. But for all of us who see, who hear and who care, this is an issue and a time to stand up and be counted.