

*Prevention in practice*

# **Maternal mortality: a neglected and socially unjustifiable tragedy**

## **Why WHO selected "Safe motherhood" as the slogan for World Health Day 1998**

*Ghada Hafez<sup>1</sup>*

### **Historical background**

The Nairobi Safe Motherhood Conference in 1987, just over a decade ago, generated global satisfaction and the hope that its outcome would be a turning point in ridding the world of maternal mortality—a truly neglected tragedy. Moreover, it is a tragedy which is socially unjustifiable since 99% of maternal deaths occur in the developing countries and among women in the most deprived sections of the population. Childbirth, a real cause for rejoicing among more fortunate, economically affluent women, becomes for the poor an event filled with tension, which may, and all too often does, leave behind motherless children and bereaved families. The Nairobi Conference drew attention to this neglected tragedy and gave rise to a comprehensive understanding of the roots and causes of the present unacceptable toll of maternal mortality in developing countries.

Why has maternal mortality in developing countries been so neglected? One major reason is that the magnitude of the problem is often not appreciated. Although maternal mortality accounts for the greatest proportion of deaths among women of reproduc-

tive age in most of the developing world, its importance is not always evident from official statistics. In areas where the problem is most severe, the majority of maternal deaths simply go unrecorded, or the cause of death is not specified. Hence there is a tendency to underestimate the gravity of the situation.

### **Maternal mortality: tip of the iceberg of maternal morbidity**

For every death among women, there are 10 more who are left with morbidities of various kinds that may have life-long crippling effects which the women endure in silence. It is very rightly stated that maternal mortality is only the tip of the iceberg of maternal morbidity and women's suffering.

The Nairobi Conference in 1987 noted with alarm that almost half a million women die each year because of complications related to pregnancy and childbirth. Global concern was expressed; and all countries participating, the international community and nongovernmental organizations pledged to take immediate corrective measures.

<sup>1</sup>Director, Health Protection and Promotion; WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt.

Received: 10/03/98; accepted: 30/03/98

## Causes of maternal mortality

### Medical factors

According to the international statistical classification of diseases and related health problems (10th revision), causes of maternal death are divided into two groups: direct and indirect obstetric deaths. Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. Indirect obstetric deaths are those resulting from a previously existing disease or a disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiological effects of pregnancy. Although regional variations exist, the following five major complications account for most of the direct obstetric deaths: haemorrhage, infection, toxæmia, obstructed labour (and rupture of the uterus) and unsafe abortion.

This medical perspective, however, provides only a partial answer to the causes of maternal mortality because the medical factors are usually only the last in a long procession of factors involved. The question still remains as to why women in developing countries die in large numbers from these complications, while women in developed countries do not. In order to answer this question and to help women to get off the road to death, and in order to design and implement effective prevention programmes, the various kinds of cause need to be understood.

### Health service factors

The fact is that the medical causes of death do not tell the whole story of avoidable maternal deaths. Investigators have found that 63% to 80% of direct maternal deaths and

88% to 98% of all maternal deaths could probably have been avoided with proper handling.

Unfortunately, in most cases, and in some countries where maternal mortality levels are still alarming, many avoidable factors continue to be identified. Lack of facilities for emergency transport, lack of or poor referral services with essential obstetric function, unavailability of blood transfusion, deficient medical treatment of complications, lack of essential supplies and trained personnel, lack of access to maternity services, and lack of prenatal and postnatal care are all crucial steps on the road to death.

### Reproductive factors

The risks posed by pregnancy for teenagers, mothers over 40 years of age and mothers with high parity are high. These groups are particularly exposed to complications during pregnancy and delivery.

### Socioeconomic factors

Socioeconomic factors play a large role in maternal death: poverty, illiteracy, malnutrition and the low social status of women are without doubt the underlying causes of maternal mortality.

## What happened after Nairobi

Two major international conferences, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995, echoed the concerns of the Nairobi Conference and urged immediate global action. Safe motherhood was deemed an essential right of all women, to be included in the agenda of all discussions about women and their rights.

In the Eastern Mediterranean Region of WHO, the Regional Committee discussed in its Thirty-fifth Session the tragedy of maternal mortality in great detail and strongly recommended that the countries of the Eastern Mediterranean Region and WHO should adopt immediate steps to reverse the situation. A proposal was put forward with wide approval to "Put more M into MCH". It was felt that the time had come to give more attention to the health of mothers, as direct beneficiaries and not only as a means to an end, the end being children.

The Regional Committee strongly recommended that mothers should receive the attention they were due in order to maintain their health throughout their life span. It was also recommended that there should be one trained birth attendant in every village—an important step to providing support to women at the most critical time in their lives.

### **Priority for the prevention of direct obstetrical deaths**

The placement of trained birth attendants and the establishment of essential obstetrical care units in peripheral areas are closely linked in importance in preventing direct obstetrical deaths. Any women in childbirth at risk of one or more of the five direct obstetrical disorders (haemorrhage, infection, toxæmia, unsafe abortion and obstructed labour) are screened by the trained birth attendant and then referred to the obstetrical care unit, a procedure which can save many lives.

A number of those countries in the Region at a relatively higher economic level took the necessary steps and produced a significant lowering in mortality rates within a short period. Other less developed countries in the Region were unable, for

lack of financial resources, to undertake basic measures such as the provision of blood transfusion facilities and surgical procedures, or to maintain the supply of antibiotics and anaesthetics.

### **A decade after Nairobi**

Where are we today in our efforts to control maternal mortality? Recent WHO/UNICEF global estimates indicate a figure higher than the earlier estimate of half a million preventable deaths per year. Paradoxically, this need not cause overly severe concern nor should it imply that no progress has been made. Data relating to maternal mortality from individual countries indicate substantial progress. At the same time most cash-strapped countries have made no progress, for various reasons. It is also true that in several countries assessment of maternal mortality rate is institution-based and in many cases is underestimated. The need for a more reliable estimate is obvious, especially for monitoring the impact of measures taken by the state.

It is clear that in any future strategy for maternal mortality control, more resources and attention should be given to priority measures such as WHO's use of the Mother-Baby Package, which is feasible in most, if not all countries, and the impact of which can be felt rapidly, thus assuring policy-makers. Designed specifically for use in national programmes in the developing world, the package consists of 18 simple interventions that have proven their capacity to reduce maternal and infant mortality in resource-poor settings.

A more encouraging trend is the political commitment at the highest level in a large number of countries. Such commitment includes social mobilization, rational allocation and effective use of necessary resources,

adaptation of already available know-how to the cultural environment, socioeconomic situation and local health services organizations, and the active participation of communities and particularly of women. Numerous national and international forums concerned with the welfare of women now regard reduction of maternal mortality as an area of highest priority.

There is also distinct evidence in most countries to indicate that the socioeconomic status of women is improving. Female literacy rates have risen, female enrolment in schools is rising every year, school drop-out rates for females have not risen, and more and more women are joining the work force and embarking upon professional careers. The dividends will be apparent within the near future. The concomitant increase i.e. coverage of primary and secondary health care, better environmental sanitation and provision of safe water to an increasing number of people contribute to an overall

improving socioeconomic situation. All these factors will undoubtedly interact and contribute in the control of maternal mortality.

The 23 countries in the Eastern Mediterranean Region have great diversity, not only in their maternal mortality rates, but in terms of most socioeconomic indicators. The Region includes countries that are among the richest in the world and countries classified by the United Nations as least developed. There are countries where 100% of deliveries take place in hospitals and others where more than 90% of deliveries are unattended by even trained traditional birth attendants. It is no wonder then that the maternal mortality rate in countries of the Region varies between 10 and 1100 per 100 000 live births.

Clearly, much remains to be done, not just in our Region but globally. This is why WHO selected Safe Motherhood as its slogan for the 1998 World Health Day.

