



Childbirth: a matter of life and death

Childbirth is a universally celebrated event, an occasion for dancing, fireworks, flowers or gifts. Yet for many thousands of women each year childbirth is experienced not as the joyful event it should be, but as a private hell that may end in death. In practically every society celebration of life is the dominant theme, while the grimmer side of childbearing is shrouded in silence; known only to those who suffer it and those who attend them.

The World Health Organisation estimates that some 500,000 women a year worldwide die as a result of complications in pregnancy and childbirth, most of which are preventable. At a recent WHO conference on the Prevention of Maternal Mortality, one of the participants attempted to make these figures more comprehensible by using an analogy of air travel:

"Imagine that every four hours, day in, day out, a jumbo jet crashes and all on board are killed. The 250 passengers are women, most in the prime of life, some still in their teens. They are all either pregnant or have just delivered a baby. Most of them have growing children at home, and families that depend on them".

Most, too, will be from developing countries where 85% of the world's births take place and 99% of maternal deaths.¹ "The figures for maternal mortality show the most startling inequity between rich and poor countries", says a WHO spokesman in Geneva. "The disparity is greater than in any other health indicator — greater even than the infant mortality rate which is generally focused on as the most telling indicator".

In developing countries maternal mortality accounts for about one quarter of all deaths of women of childbearing age, whereas the figure for the U.S. is less than 1%². Overall, it has been estimated that the chances of dying in pregnancy or childbirth are between 50 and 200 times greater for women in developing countries than they are for women in the developed world,¹ with teenage mothers, those over 35 years of age, and those who have already given birth 5 times before, at particular risk. According to WHO, mortality rates per 100,000 live births are approximately 640 for Africa, 270 for Latin America, and 420 for Asia,

with an average of 30 for the developed world as a whole.

Among the most commonly recorded causes of death are haemorrhage, infection, toxæmia (high blood pressure associated with pregnancy), obstructed labour and illegal abortion. However, what is written down by the medical staff as the final cause of death is just the last step on the road; it reveals very little of the journey thus far — of the clinical complications preceding death, of the social setting in which it occurred, of pregnancy too early, too late or too frequent. Thus haemorrhage or infection may be the result of a backstreet abortion performed with knitting needles or "magic potions". It may be the result of an obstructed labour in which the uterus has ruptured, or untrained birth attendants have assisted with unwashed hands.

Furthermore, the clinical aspects of a maternal death are only part of the picture. "Each death has its roots in a complex interplay of economic, social and cultural factors", says the World Bank. "Maternal mortality is intimately tied up with a country's stage of development".

In many parts of the third world there are too few trained personnel, and too little money, or not enough political will, to extend the network of primary health care out to the corners of society, where communities may still be living with none





of the comforts of the modern world such as electricity, piped water and sanitation. Thus, the nearest health post may be several days' journey away from a village, over terrain without an all-weather road. There may be no transport to get a sick woman to hospital other than a bicycle, bullock cart or vegetable lorry if she's lucky, and no means of calling in help from outside. Even where medical care is accessible, shortages of equipment, drugs or blood for transfusion are common frustrations.

As well as the physical barriers common in developing countries, there are often financial barriers too. The necessity to pay fees — or even bribes — can put modern health care beyond the scope of very poor people, who are often left bitter at the helplessness poverty has imposed upon them. Furthermore, a woman working to support her family may be reluctant to seek help until she is simply unable to keep going.

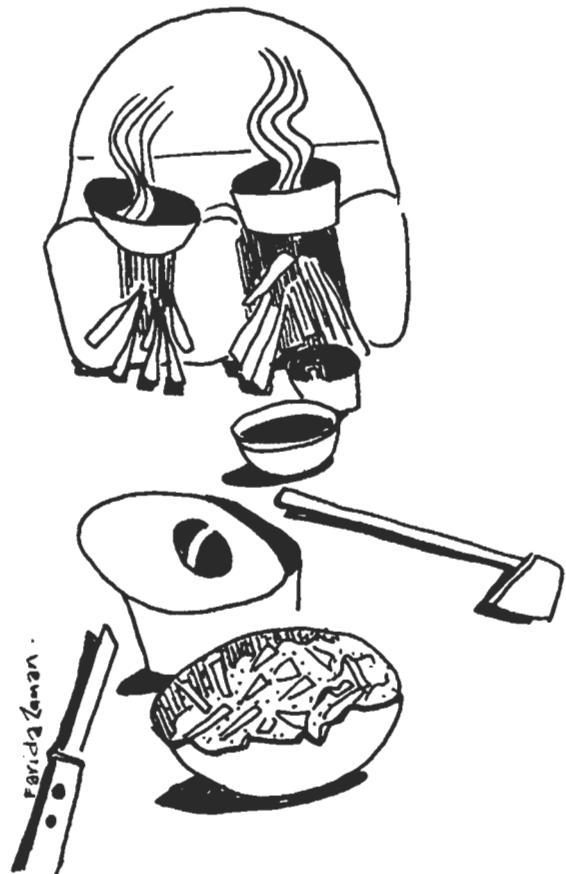
Cultural and social barriers can be as unsurmountable as the practical ones. In parts of Papua New Guinea, for example, where the network of health facilities is generally good, the fact that health posts are predominantly staffed by men inhibits women with obstetric problems from seeking help. In many societies it is taboo to discuss sexuality and human reproduction, even between mother and daughter; so ignorance and inhibition abound.

Women without education or much contact with the outside world may know nothing of modern medicine, or may prefer to put their trust in the untrained traditional birth attendant who is a familiar and often respected member of the

community. However, the constellation of traditional beliefs surrounding childbirth frequently adds to the risk and pain of delivery. In some societies childbirth is considered impure and "polluting" and the woman in labour must withdraw to a secluded place. If labour should be prolonged or difficult, it may be taken as a sign of sexual infidelity, and the woman neglected or castigated, even in the midst of her suffering, until she "confesses", gives birth or dies.³

The low status of women implied by such action is a common feature of underdevelopment and poverty and an enormous amount of maternal suffering and death can be laid at its door. Paradoxically, in societies where the welfare of women is given low priority, they are often the lynch-pin of their families; their ill-health or death can leave young, helpless children extremely vulnerable, and adult relatives devastated at the loss. A study in Bangladesh showed that when a mother dies in childbirth, the infant she leaves behind has a 95% chance of dying within the first year.⁴

Low status of women means discrimination against girls from birth, which stores up problems for their childbearing years. In many societies



women and girls are served last at mealtimes, eating whatever is left after the menfolk have had their fill. Studies in some areas have found dramatically higher rates of undernourishment in girls than in boys from the same communities. And there is evidence, too, that girls may be given less care during sickness than boys, and that where health care costs money parents will only be prepared to spend it on sons.⁵

Separately and cumulatively these under-investments in the girl take a toll on her health. Undernourishment and infections tend, among other things, to stunt and distort growth and to cause anaemia. It is estimated that at least two thirds of pregnant women in developing countries are clinically anaemic.⁶ This condition saps a woman's strength making her more vulnerable to infection, and there is added danger to an anaemic

status of women. In Africa around 55% of teenagers at any one time are married; on the Indian Subcontinent the figure is 58%, while in the United Kingdom it is 4% and in Australia 2%.⁸

Low self-esteem is the other side of the coin of low status: girls tend to grow up accepting their lot as immutable and hardship, however extreme, as natural. Lack of education means that new ideas are slow to catch on, and even when modern health facilities are available, they are frequently ignored by those whose need is greatest. But whether the reason be lack of access to, or underutilisation of facilities, WHO estimates that fewer than half the births in developing countries are attended by trained personnel.

High fertility is another problem that is affected by the status of women. Though large families are often necessary in poor communities to spread

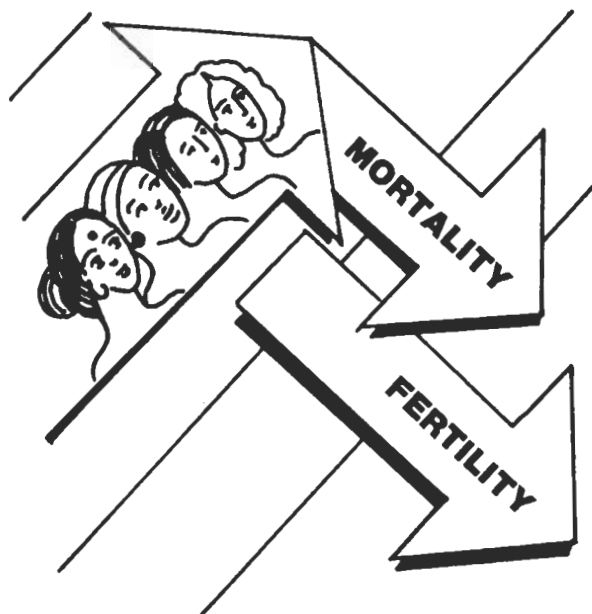


mic mother if she should haemorrhage. Where a mother's growth is stunted by undernourishment there is a greater likelihood that she will suffer obstruction in childbirth because of disproportion between the size of the baby's head and her pelvis.

Obstructed delivery due to cephalo/pelvic disproportion is a particular risk also for teenage mothers, who will not be fully grown themselves. It is estimated that at the onset of menstruation a young woman has approximately 4% more height to attain, and as much as 12-18% more pelvic growth.⁷ Teenage marriage and motherhood are also hallmarks of underdevelopment and low

the workload and to look after parents in old age, many women get pregnant and bear children continuously throughout their fertile years because they have little choice: their social status depends on it; they have not been trained to support themselves outside the family, and family planning is either illegal, inaccessible, unknown to them, or not a matter of female choice. Yet an estimated 50 million women a year do finally take the matter into their own hands and seek termination of their pregnancy.⁹ It is frequently a desperate and lonely solution to an intolerable situation. Half these abortions will be illegal, performed by unqualified people, and in parts of

heavily Roman Catholic Latin America induced abortion is the cause of more than 50% of maternal deaths.¹⁰




High as they are, the maternal mortality rates do not tell the full story of suffering caused by lack of access to professional help in pregnancy and labour. For every woman who dies there are countless more who survive with long-term or permanent damage to their health. Sometimes this merely weakens them, making everyday life more of a struggle. But some health problems can


drastically affect a woman's social standing, and even lead to ostracism from society.


"The picture of maternal mortality and morbidity was much the same in the Western world less than a century ago, when there was widespread poverty", said WHO "But the historical analysis is not altogether fair. A century ago obstetric care did not offer many chances of survival even if it could have been spread more evenly, whereas today we *have* the weapons available to make childbirth much safer. We have antibiotics, blood for transfusion and caesarian section. That so much suffering persists today in spite of this knowledge is a tragedy, and the present challenge to society".

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 World Bank - Washington

 WHO - Geneva

 UNFPA - New York

"The women of the Third World are the poorest of the poor, but their work can make the difference between poverty and hope. It is their backs that are bent in the fields to till and plant, to weed and fertilize and harvest. Their backs are bent at the well to draw water and carry it home. Their backs are bent under loads of fuelwood and the weight of young children. Their backs are bent over cookfires and looms and market stalls and sickbeds.

"For too long, those bent backs have been too little visible to those who plan development in terms of macroeconomic policy, of roads and power lines, of schools and hospitals, of factories and ports and irrigation projects. We have assumed that the benefits of these programs would, in time flow to men and women alike. But our assumptions have been imperfect, our results uneven. Macroeconomic planners have slighted the growth that comes from the bottom up. In developing nations -- but not in those nations alone -- too many women are at the bottom. Their arms hold the family together. Their hands build the foundation of stable, growing communities. But development efforts have not lent enough strength to those arms, have not entrusted enough resources to those hands. And, along with women, development itself has suffered. To sustain itself, development must help women up." - Barber Conable, President, World Bank, February 10, 1987, Nairobi, Kenya