B6 | MATERNAL MORTALITY: NEED FOR A BROAD FRAMEWORK OF INTERVENTION

Global burden of maternal mortality

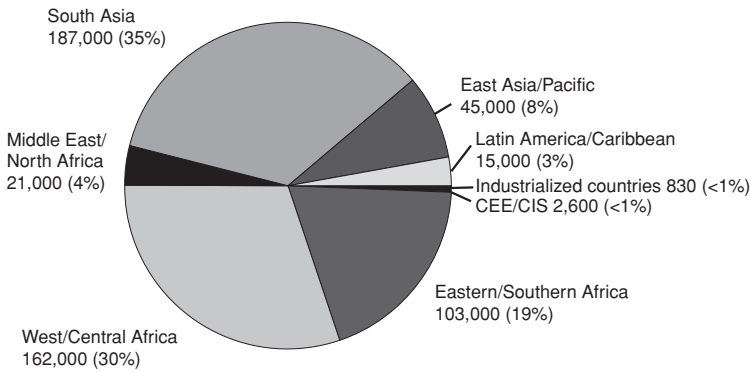
The number of maternal deaths is unconscionably high. An estimated 500,000 women die each year in pregnancy and childbirth.[1] An estimated 10 million more women suffer serious maternal morbidities,[2] including debilitating and socially devastating conditions such as uterine prolapses and obstetric fistulae.[3] In addition, substantial proportions of the 3 million newborn deaths and 4 million stillbirths that occur each year are the result of maternal conditions or of acute events in and around the time of delivery.[4]

The World Health Organisation (WHO) defines maternal mortality as 'the death of a woman while pregnant or within 42 days of termination of pregnancy or from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes', with an additional classification of 'direct', 'indirect' or 'incidental'.[5] *Direct* deaths result from obstetric complications, while *indirect* deaths result from a condition that is not directly related to obstetric causes but is aggravated by the effects of pregnancy. In developing-country settings, studies indicate that 20 per cent or more of all maternal deaths are due to indirect causes.

The patterns of maternal mortality reveal large levels of inequity between and within countries – 99 per cent of maternal deaths occur in developing countries, with 86 per cent occurring in South Asia and sub-Saharan Africa alone.[6] Fourteen countries have maternal mortality rates (MMRs) of at least 1,000 per 100,000 live births, of which all except Afghanistan are in sub-Saharan Africa: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of Congo, Guinea-Bissau, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone, and Somalia. Wide disparities also exist within countries. Class, too, plays a defining role in maternal mortality and morbidity statistics, with studies in multiple countries showing that the MMR amongst poor women is four times higher than amongst wealthier groups.[7]

Three fundamental causes of maternal mortality can be identified:[8]

- medical causes, consisting of direct medical problems and pre-existent or coexistent medical problems that are aggravated by pregnancy, such as anaemia and malaria;
- health systems laws and policies that affect availability, accessibility, acceptability, and quality of reproductive health services; and
- underlying socio-legal conditions.



B6.1 Regional distribution of maternal deaths. *Note*: Percentages may not total 100 because of rounding (*source*: WHO, UNICEF, UN Population Fund and the World Bank, *Maternal Mortality in 2005: Estimated developed by WHO, UNICEF, UNFPA and the World Bank*, Geneva, 2007, p. 35)

Globally the five most immediate medical causes of maternal death are: severe bleeding (haemorrhage) (25 per cent); infections (15 per cent); unsafe abortions (13 per cent); eclampsia (12 per cent); and obstructed labour (8 per cent).[9] Indirect causes (responsible for 20 per cent of maternal mortalities) include coexisting medical problems such as: malaria, anaemia, jaundice, and tuberculosis. There is also a contributory role of increased incidence of domestic violence during pregnancy, associated with cultural and stigmatised notions of sexuality and morality.

Underlying these medical causes is a range of systemic factors. These include discrimination on the grounds of gender, race, ethnicity, religion, and caste, and social factors such as lack of education and employment opportunities, increased workload (both outside and domestic), and political and legal issues. Particularly significant are the underlying patriarchal values and norms that define state policy differently across countries. Moreover, differential legal provisions relating to abortion, family planning, and medical consent, together with coercive and repressive population policies, also account for heightened risks.

Risk factors are not limited simply to demographic variables (age, parity, etc.) but also relate, for example, to issues of social stigma surrounding sexual behaviour and seasonal peaks in women's workload. In addition, gender biases in the structure and culture of health services provision further augment these risks. For instance, a recent Human Rights Watch Report on maternal deaths in Uttar Pradesh, a state in north India, identified four important reasons for sustained high rates of maternal mortalities – barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of health services.[10] Gender analyses also suggest that maternal mortality is linked to a wide

range of factors in women's lives, including the value placed by women and by their families and communities on women's health, women's economic position, their access to education and information, and their capacity to make autonomous decisions.[11]

While these socio-economic and legal factors underlying maternal mortality have been pointed out, most interventions directed at reducing maternal mortality have a limited focus on medical causes and on the related factors of service provision.

Addressing maternal mortality: historical interventions, emerging ideas

Maternal child health to family planning In the report on the first 10 years of WHO, maternal and child health (MCH) was a clearly identified area of action.[12] The major thrust in the 1950s was on providing technical support for training a sufficient number of personnel (including domiciliary training for midwives in order to raise the standards of home births), creating administrative divisions of MCH within national health systems, and integrating MCH services with general health services.

International cooperation in the area of maternal health gained prominence in the mid 1960s, when Western donor countries and international agencies first started funding MCH programmes in developing countries. However, in the WHO's report on the next 10 years (1958–67), which overlapped with this period, maternal health featured much less prominently.[13]

By the 1970s, the family planning movement had largely influenced those involved in issues of maternal health. Following the World Population Conference in Bucharest in 1974, the clear adoption and prioritisation of the family planning approach was evident in the WHO's approach to dealing with issues of maternal mortality and health.[14] For other actors, too, such as UNICEF and USAID, the focus on, and funding of, MCH was geared to child health and family planning.

The Safe Motherhood Initiative (SMI) In 1985, two academics from Columbia University[15] wrote a highly influential paper that put the issue of maternal mortality on the international health policy agenda. The first international conference devoted to maternal mortality (Safe Motherhood Conference, Nairobi, Kenya, 10–13 February 1987) was sponsored by the World Bank, WHO, and UNFPA, and led to the launch of the Safe Motherhood Initiative (SMI). International agencies involved in the SMI coalition included five UN agencies (WHO, UNDP, World Bank, UNFPA, and UNICEF) and two NGOs (the Population Council and the International Planned Parenthood Foundation (IPPF)). SMI was aimed at improving maternal health and reducing maternal deaths by 50 per cent by 2000.[16] This initiative led to a series of national and international conferences that made 'safe motherhood' a widely understood term in the public health realm. However, the initiative has been criticised for

14 Women's health problems are often seen only in relation to child-bearing(Indranil Mukherjee)

focusing on only increasing awareness and to a far lesser extent on mobilising resources for safe-motherhood activities (which itself was a narrow agenda).[17] In the decade that followed, safe-motherhood strategies were developed based on the different phases in a woman's reproductive cycle – pre-pregnancy, antenatal, delivery, and post-partum periods.

In 1987, the international women's movement also launched a day of action focused on maternal mortality. The success of this event led to a 10-year campaign (which ended in 1996), coordinated by the Women's Global Network for Reproductive Rights (WGNRR), to reduce maternal mortality.

Towards a universal reproductive rights approach In 1994, the International Conference on Population and Development (ICPD) recommended that countries move away from the traditional family planning projects to a broader perspective of reproductive health. Although not primarily focused on maternal health and safe motherhood, the Programme of Action developed at ICPD placed, and has helped to keep, maternal health within a reproductive health agenda. Other international conventions relevant to safe motherhood include those on age at marriage (Convention on Consent to Marriage, Minimum Age of Marriage and Registration), maternal protection at work (Maternity Protection Convention), and against torture (Convention against Torture). The ICPD Programme for Action and the subsequent Beijing Platform for Action adopted at the Fourth UN World Conference on Women in Beijing in 1995, along with their follow-up conferences, held every five years, have been very influential in shaping policies on maternal and reproductive health in various countries. The importance of maternal health and survival was reinforced in 2000 when it was included as one of the eight Millennium Development Goals

(MDGs) (with a commitment to reduce MMR by three-quarters between 1990 and 2015).

Maternal mortality: a human rights issue More recently, a human-rights-based lens has been used to examine the underlying causes of maternal mortality and morbidity. Maternal mortality and morbidity, under such a construct, are seen as human rights violations, and access to maternal health a universal human right. However, human rights treaties and conventions do not include an explicit right to women's health. Nevertheless, human rights committees have now included a gender perspective in their interpretation of human rights and state that failure to address the preventable causes of maternal death is a violation of women's human rights, for which states can be held accountable.[18] An understanding is now emerging, within the human rights framework, that it is important to highlight the fact that social injustices contribute to avoidable maternal deaths. This approach considers the reduction of maternal mortality as a threshold objective in a comprehensive strategy to ensure a woman's right to a life-enhancing pregnancy and childbirth. As Freedman points out, 'Once an issue is recognised as a human right, there is a legal obligation to take steps that are "deliberate, concrete and targeted toward [the] realisation of the right."'[19]

UNICEF also emphasises that an overall environment supportive of women's rights is needed in order to enhance health care provisions, to address gender discrimination, and to remove inequities in society through the adoption of human rights approaches. In September 2008, the European Parliament passed a resolution recognising maternal deaths as a human rights issue. In June 2009, the UN Human Rights Council passed a resolution declaring that preventable maternal deaths are indeed a violation of women's human rights.

Maternal mortality: a public health concern

The various intervention strategies – ranging from SMI in the 1980s to the latest implementation of the MDGs – have emphasised the concept of reproductive health, particularly maternal health and safe motherhood, equating this with the concept of women's health. There is no denying the fact that reproductive health constitutes an important aspect of women's health. However, the challenge is to define priorities within this framework according to the objective and subjective definitions of women's needs, and to make these priorities a part of a larger development programme, based not only on equity of distribution but also on access to, and control of, productive resources.

Unfortunately, public health issues in specific contexts and locales have been ignored in an attempt to present a homogeneous framework of 'universal' reproductive health rights. In this quest, however, the epidemiological basis of maternal health, the immensity of women's health problems, and the social constraints on women's lives reveal the inadequacy of an isolated strategy in

Box B6.1 Human rights and maternal mortality

The Convention on the Elimination of All Forms of Discrimination Against Women requires States parties to:

'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (Article 12.2).

The International Covenant on Economic, Social and Cultural Rights requires States parties to take steps to provide for:

'the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child.'

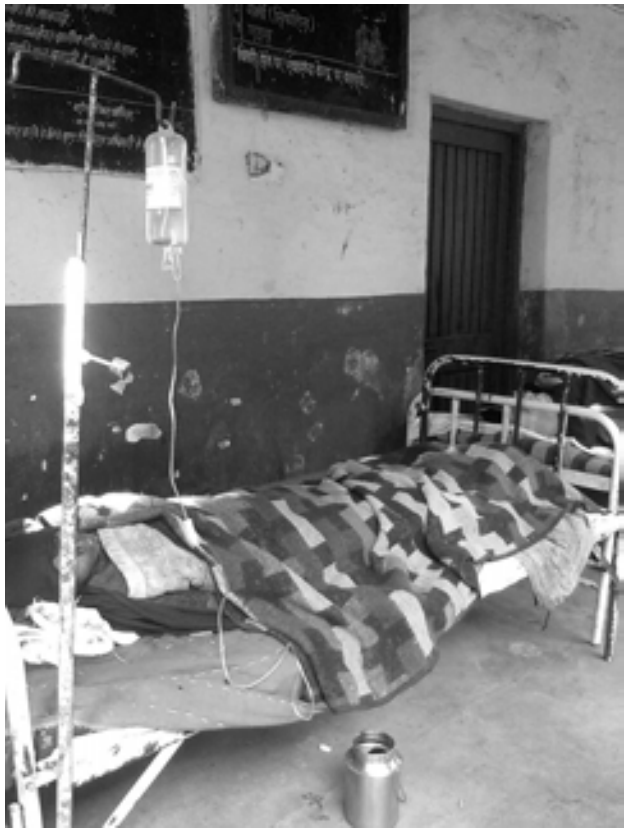
The UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring this treaty, has stated that this treaty obligation must be:

'understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information' (General Comment 14, para.14)

the context of 'the expressed needs of women for land rights, freedom from atrocities, food, security system, minimum wages and communal harmony along with the need for health services'.[20]

Such a 'uniform' strategy places, within the domain of reproductive problems, issues that could be classified as 'medical' causes, but which do not necessarily have their roots in a medical aetiology. For instance, while reproductive health interventions cover nutrition and infectious diseases during pregnancy and childbirth, they fail to address the underlying issues of food security, poverty, inadequacy of public distribution systems, etc. Failure to address these underlying causes raises further concerns of a 'superficial intervention strategy',[21] and underplays the importance of paradigm shifts in local heath systems policies.

Further, the life-cycle approach preferred by several new-age maternal health rights proponents continues to identify reproduction as the criterion for defining the stages of life. This strategy leads to simply further medicalising reproduction, with an effort at homogenising the health care needs of women across the globe, with little attention being paid to local needs and social realities.



15 Women patients at a hospital in Madhya Pradesh, India where several deaths took place over a short period (Sarojini.N.)

The increased stress on family planning and fertility regulation as a part of maternal health strategies, and on other technocentric strategies for dealing with social and structural issues, raises concerns about the appropriation of these issues by the population control lobby, a phenomenon that is glaringly visible in the nature and source of funding available for maternal mortality and morbidity programmes in developing countries today. There is, therefore, a need to understand fully the initiatives to end maternal mortality and to see them from a public health perspective.

There is no doubt that safe deliveries, whether these take place in institutions or in homes, combined with safe and effective contraception, access to safe abortions, and freedom from violence, are an important part of maternal health care. However, narrowly focused strategies, particularly those concentrated on increasing institutional deliveries and on decreasing maternal mortality, should instead be looking at providing comprehensive and easy access to health and health care and its determinants. Maternal health needs to be addressed within the larger framework of collapsing health systems further burdened by repressive policies and programmes, affecting the socio-political context of

Box B6.2 Institutional deliveries – not a panacea

The focus of the Indian government's strategy for reducing maternal mortality and morbidity has been on ensuring institutional deliveries – through a scheme known as the Janani Suraksha Yojana (JSY). Women who deliver in accredited institutions are provided with a cash incentive. The findings of a recent report[23] by a fact-finding team investigating a spate of maternal deaths in Barwani district in Madhya Pradesh (one of the poorest states in India) raise doubts about an uncritical reliance on such an approach. Some of the findings of the study are as follows:

- Women are being forced to travel great distances with a lot of difficulty to access care during delivery, in order to be eligible for the incentive provided under the scheme. This is because primary health facilities that are closer to their homes are not prepared to conduct normal deliveries.
- Institutional readiness to handle the increased caseloads of women approaching them for deliveries is an important issue. While the National Rural Health Mission (NRHM) has spent large amounts on preparing institutions to provide emergency obstetric care, it is obvious from the investigation that such care is, in fact, not being provided. Quality of care remains an important issue. Skilled Birth Attendance (SBA) is inadequate; adequate infection control measures are not being followed; irrational use of oxytocin and antibiotics is prevalent; and women are being subjected to abuse and violence during labour. However, none of these factors is measured as an indicator when monitoring success in maternal health interventions. Rather, the number of institutional deliveries is assumed to be the proxy for better maternal health care.
- The exclusive focus on institutional deliveries has resulted in a total lack of attention to either antenatal or post-natal care. In a district with a very high prevalence of anaemia, no concerted efforts have been made to investigate and address the issue. Thus, a 'one size fits all' policy seems to be the norm.

health. This is especially important in a context where privatisation, cutbacks in allocation to the social sector, shrinking wage structures, declining work opportunities, and dwindling food security are hitting women the hardest. In such a situation, basic survival needs cannot be given a secondary status. As Qadeer asserts, 'To do otherwise would mean rejecting women's context, their perceptions and their strategies for survival.'[22]

Notes

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19 Freedman, L. P. (2001). 'Using human rights in maternal mortality programs; from analysis to strategy'. *International Journal of Gynecology and Obstetrics*, 75(1): 51–60.

20 Qadeer, I. (1998). 'Reproductive health: a public health perspective'. *Economic and Political Weekly*, 33(41): 2675–84.

21 Ibid.

22 Ibid.

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