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Addressing Maternal Mortality : A Public Health Perspective

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Abstract

Reproductive health is one of the largest focus areas of the health sector in current years. Though there is a strong focus on women's health in the form of 'reproductive health', it is mostly seen as a way of improving the 'health of society' rather than a redressal of a gross injustice to women per se. Though it is a big need of women to have good quality reproductive health services, if these are not set within an overall understanding and sensitivity towards gender discrimination and women's rights, they tend to reinforce the notion of women as mothers and undermine the focus required for other type of morbidities. It is also true that women health issues (maternal mortality included) cannot be addressed without addressing social determinants of health including gender equity. 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 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. Present paper examines the current status of maternal health, considers the key priorities of policies and programmes, and proposes options for interventions to achieve a reduction in maternal mortality and over all improvement in women's health.

Keywords : Maternal, Morbidity, Social Determinants, Janani Suraksha Yojana

Introduction

Sweeping changes in the public health have transformed life over the past century. The 1970s and 80s have witnessed some very progressive and comprehensive initiatives from governments and international organizations, including the WHO led global effort to achieve "Health for All" by the year 2000. Representatives from more than 130 countries met in Alma –Ata and signed a declaration stating that inequality in the health status of the people ,is politically, socially, and economically acceptable. More than three decades after the Alma Ata Declaration, however, Health for All remains an elusive goal. Millions of people die prematurely from diseases that are preventable or curable.

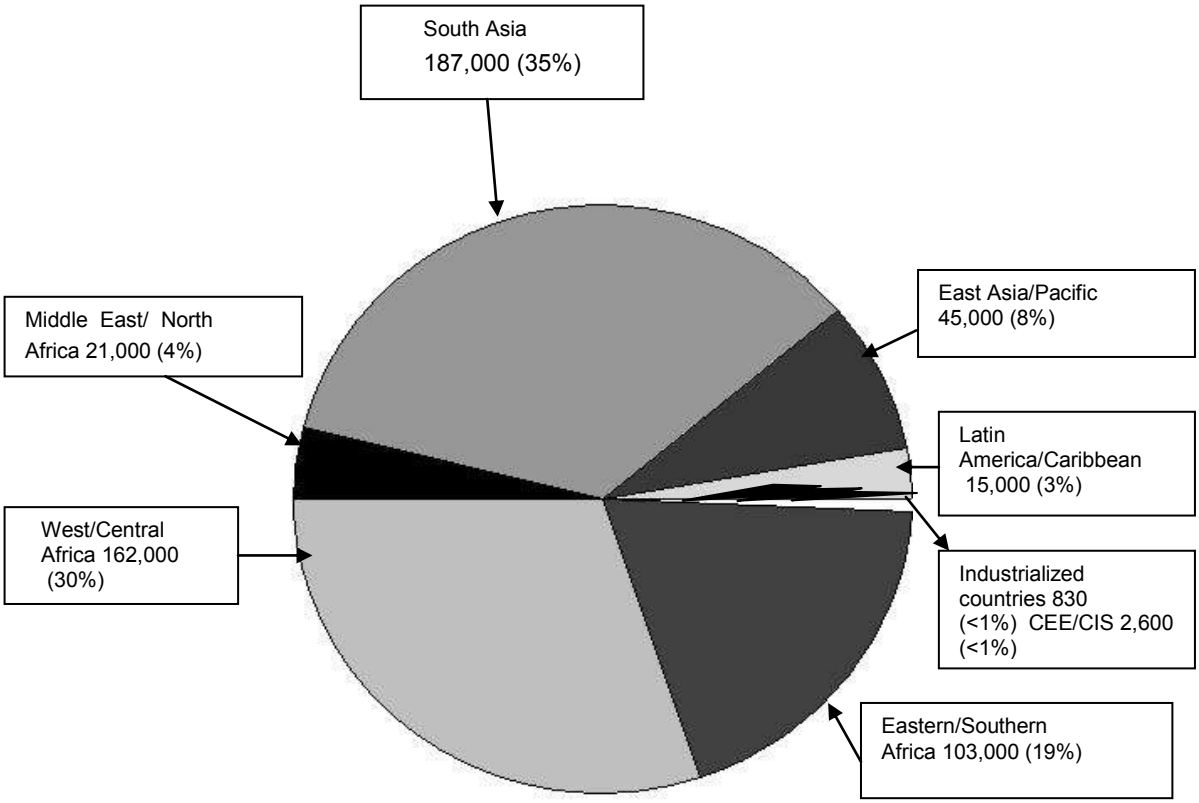
Globally, the number of maternal deaths is alarming. An estimated 500,000 women die each year in pregnancy and childbirth.[1] Almost 99% of these deaths occur in developing countries. Half of all maternal deaths occur in sub-Saharan Africa and another major portion in southern Asia. The pattern of maternal mortality reveals that there were much variability between countries with a maternal mortality ratio of 1000 deaths per 1,00,000 live births in developing countries versus 16 deaths per 1,00,000 live births in countries of developed regions.Fourteen countries have maternal mortality rates (MMRs) of at least 1,000 per 100,000 live births. An estimated 10 million more women suffer serious maternal morbidities,[2] 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] Wide disparities also exist within countries. Class, too, plays a defining role in maternal mortality and morbidity statistics, the MMR amongst poor women is four times higher than amongst wealthier groups.Thus, maternal mortality continues to be a major public health problem.

Understanding maternal Mortality and its causes

The World Health Organisation (WHO) defines termination of pregnancy or from any cause related to or aggravated by the pregnancyor 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.

maternal mortality as 'the death of a woman while pregnant or within 42 days of

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); andobstructed labour (8 per cent).9 Indirect causes (responsible for 20 per cent of maternal mortalities) include coexisting medical problems such



Regional distribution of maternal deaths.
(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)

Dwelling further on the indirect causes of maternal ealth, one comes across various factors some of them very interesting. Research findings about India's maternal health status indicate that the pregnancy pattern in India—'too early, too many and too close together' enhances the risk of maternal mortality and complications. It also highlights that maternal deaths could be reduced by 25-40 percent if all unwanted pregnancies are prevented. If child bearing is confined to the age group 20-39, MMR would be reduced by 11 percent. The elimination of the fifth and higher order births would reduce MMR by 4 percent.

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domestic violence during pregnancy, associated with cultural and stigmatised notions of sexuality and morality.

Underlying these medical causes is a range of systemic and socio economic 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, 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, 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.

Major interventions

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.

The Safe Motherhood Initiative (SMI) 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.[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, 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. 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.

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.

As 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

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**.**

Conclusion

Although public health has traditionally focused on improving the health of the majority, policies and programs can be reoriented to better meet the needs of the women health in general and maternal survival and well being in particular. There are proven techniques for increasing the benefits that accrue to the maternal survival from publically funded health programs.

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 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.

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