On Safe Motherhood

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IN the Book of Genesis we may read these words: "Unto the woman He said, I will greatly multiply thy sorrow and thy conception; in sorrow shalt thou bring forth children". But in the present time, neither the conception nor the sorrow is evenly distributed about the world. Surely the most striking fact about maternal health in the world today is the extraordinary difference in maternal death rates between industrialized and developing countries. In the industrialized countries maternal deaths are now rare events. There, the average life-time risk for a woman of dying of pregnancy-related causes is between one in four thousand and one in ten thousand. In contrast, for a woman in the developing countries the average risk is between one in fifteen and one in fifty. These countries commonly have maternal mortality rates 200 times higher than those of Europe and North America; the widest disparity in all public health statistics.

Why have these inequities in maternal death rates only recently become apparent and a cause of grave concern to governments and to WHO? The main reason is that until lately the size of the problem was largely unknown. Most of the countries where maternal mortality is high are also countries where even registration of deaths, let alone certification of cause of death, is greatly deficient or absent. Since 1974, however, some meticulous community-level surveys have been carried out in at least ten countries in Africa, Asia and the Americas. These have enabled us to correct the false impressions given through under-registration and for the first time to see the problem as it really is.

Sound estimates based on new data are thus the foundation of our current understanding and concern. There are other features of maternal mortality which impel us to give it a special priority. It has been a *neglected* tragedy; and it has been neglected because those who suffer it are neglected people, with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants, and above all, women. (It is after all a woman's problem, is it not? Or is it?).

Discrimination against Women

One of the defects of modern society which is most damaging and impossible to justify is the persisting discrimination against women. "Women hold up half the sky", goes the Chinese saying. Really, somewhat more than half in many parts of the third world, if the truth be told. They plant and harvest much of the food; they process and preserve it; women always cook the food, including carrying fuel and the water needed. All this in addition to bearing, feeding and in general caring for the children. They nurse those of the family, old or young, who need such care. They make, in short, an indispensable contribution to the national, local and the domestic economy, and they are the main providers of comfort and care to every family. Despite all this there persist many forms of obvious discrimination against women: a much smaller proportion of girls than boys is enrolled in primary or secondary school; still in some parts of the world girls under five have much higher death rates than boys; higher proportions of girls than boys are severely malnourished. All such discrimination is not merely reprehensible in itself, but also has a more or less direct relationship to maternal mortality.

The cause of a maternal death often has some of its roots in a period of a woman's life preceding the pregnancy. It may be in infancy, or even before her birth, that deficiencies of calcium of Vitamin D or iron commence. Continued throughout childhood and adolescence, they result in a contracted pelvis and eventually in death from obstructed labour, or in a chronic iron deficiency anaemia and often death from haemorrhage. The train of negative factors goes on through the stages of a woman's life; the special risks of adolescent pregnancy; the maternal depletion from pregnancies too closely spaced; the burdens of heavy physical labour in the reproductive period; the renewed high risk of childbearing after 35, and worse, after 40; the compounding risks of grand multiparity; and running through all this, the ghastly dangers of illegal abortion to which sheer desperation may drive her. All these are like links in a chain from which only the grave or the menopause offer hope of escape.

But now there is a way to break these chains. The commitment by all the governments of the world to the Health For All Strategy gives us a ray of hope. For this is a problem to which the only solution must involve a certain basic *equity*, not merely from an ethical or political point of view, but because these deaths occur disproportionately to the poor in remote rural areas; so that we can only succeed in making a major impact by ensuring for all women access to the essential elements of preventive and promotive maternal health and family planning care; and particularly essential obstetric care in life-threatening emergencies of pregnancy and childbirth.

Preventive and Therapeutic Care

To take this combination of preventive and therapeutic care to the most peripheral level possible, the only approach which can succeed is that of Primary Health Care. A well-planned combination of

Text of the address by Dr. Halfdan Mahler, Director-General, WHO, at the Conference on Safe Motherhood at Nairobi in February 1987.

the community's and the families' own efforts with the inputs of governments and agencies offers the best hope of success.

Local health care however cannot exist in a vacuum. It needs technical and management support. It is at the district level (or governorate or country or department, however it is termed) that the health centres, aid posts, and the whole primary health care network, are administerted. It is the district team which provides almost all the support and supervision of the health personnel and much of their training too. It is the district hospital which provides, or could provide, the most essential elements of midwifery and obstetric care. The district therefore is where we must focus more of our efforts to reduce maternal mortality, in addition to efforts to mobilize communities.

I have spoken so far about maternal deaths. I must, however, point out that in a large number of developing countries there is an even greater number of women who survive only with severe damage to their health. Let me say here only that some of the worst forms of this maternal morbidity are so devastating to the personal, marital and social life of the woman that many a time she must bitterly wish she had died. However, exactly the same kind of measures which would prevent maternal deaths will also prevent this maternal morbidity, and thus from the practical point of view will not distinguish further between mortality and morbidity.

This is an appropriate point for me to remind you, nevertheless, that over 50 per cent of women in the world do not have the assistance in childbirth of any trained person whatsoever. Not only are they thus exposed to grave dangers such as sepsis or of complications, but they have of course no means whatever for the relief of pain. For them, obstetric analgesia is a remote dream. They are exposed to the full rigours of the agonizing labour pains, the very existence of which their fortunate sisters of the developed countries have by now almost forgotten. Lest we forget them, however, let me quote the apt comment of Medea in the Greek tragedy of that name written in the fifth century B.C. : "Men say that we women live a life without danger at home, while they must go forth to fight. How wrong they are! Thrice would I rather stand up and face the battle spear than bear the pains of labour once!".

Among the many underlying causes of maternal mortality, the contribution made by unregulated fertility is particularly important. This brings us to the important related topic of family planning. WHO's policy on family planning is based on the recognition of family planning as an integral and inseparable part of maternal and child health programmes. Family planning is indispensable in the struggle to prevent maternal deaths. Apart from the high-risk groups mentioned earlier, we would be wilfully blind if we failed to acknowledge the millions of illegal abortions carried out every year, and the resulting scores of thousands of deaths from haemorrhage and septicaemia. Since the great majority of abortions arise from lack of knowledge of contraception, or failure to use it, or inability to obtain the means, family planning is the obvious way to save these thousands of pitifully wasted lives.

Tragedy of Multiple Causes

We face a tragedy of multiple causes, and we must confront the challenge with a multiple strategy. There are the long-term objectives of social and economic development; there is need *now* for a more determined effort to end female illiteracy. Above all there is much to be done—now—in the health sector. But this action of the health sector must also be multiple and correctly balanced in its approach. We must stop behaving as if there were a single magic bullet which could slay this dragon! We need four strings to our bow. Under the umbrella of the Health For All Strategy, these are the four elements needed:

First, adequate primary health care, and an adequate share of the available food, for girls from infancy to adolescence; and family planning universally available to avoid unwanted or high risk pregnancies;

Second, after pregnancy begins, good prenatal care, including nutrition, with efficient and early detection and referral of high risk;

Third, the assistance of a trained person for all women in childbirth, at home as in hospital; and

Fourth, women at higher risk, and, above all, women in those dire emergencies of pregnancy, childbirth and puerperium, must all have effective access to the essential elements of obstetric care.

A maternal health programme with one of these four elements missing is like a table lacking one of its four legs.

I wish to take as an example for particular attention the last of the four elements, access to essential obstetric care. The ability of small district and rural hospitals to carry out essential functions of midwifery and obstetrics, such as a Caesarean Section or a blood transfusion, saves many more live than any amount of high technology at the tertiary hospital of the capital city. Family planning and good primary health care before and during pregnancy could cut down considerably the number of potentially fatal complications, let us say by a half or two-thirds. Yet our investigations have shown that there is always a significant proportion of complications which could not have been predicted or prevented. For these women speedy access to emergency care is a matter of life or death. All the studies of the causes of maternal mortality in which WHO and UNFPA have collaborated lately with institutions in developing countries show cleary that the essential elements of obstetric care must be brought much nearer to the woman of these regions than they are today.

Need for Research

Although we do now have a great deal of know-

(Continued on page 128)

positive in 1984, but the moderately positive "psychiatrist" remaining stable.

The concept of "psychiatric nurse" was the least positive. However, no attempt was made to trace any formative influence that might have induced such attitude.

The studies were carried out in 1981 and 1984, prior to the campaign by the New Zealand Nurses' Association to promote the image of the nurse (eg "Nurses are Worth More") and 1985 has been termed "the year of the nurse" (Keith, 1986).

Should a study be carried out again today, one might expect that the already positive stereotype of the concept "general nurse" would be even more so. Nurses have good reason to regard themselves as well trained, highly skilled professionals with a vital role to play in the health care system.

The public, or at least some of the more reflective of them, regard nurses in this light.

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Author notes: This study was supported in part by a New Zealand Nursing Education and Research Foundation grant and by an Internal Research Committee grant from Victoria University, Wellington.

(*Courtesy:* NZ Nursing Journal)

On Safe Motherhood

(Continued from page 120)

ledge about the causes of maternal deaths and how to prevent them, yet if we are effectively to apply this knowledge in a wide range of different conditions, there is still need for research. There is need to clarify in each country's own circumstances the particular pattern of preventable causes of maternal deaths, and to identify the potentials for improvement in that country's own context. There is need also for much health systems research, or operational research as it is sometimes termed, to evaluate the feasibility and effectiveness in different regions of many recent ideas and technologies. These cover a range as diverse as plasma substitutes, maternity waiting homes, detection of anaemia, delegation of clinical functions, optimizing the organization of existing health facilities, improving the logistics of supply and blood transfusion services, and many others. WHO is ready to respond to this challenge and Provide its technical support to national institutions in this research; and WHO is particularly in a good position to do this. Of course, financial resources also have to be mobilized for this purpose.

Nevertheless, the need for research certainly should not delay action. We know already how to prevent most of the commen causes of maternal death, such as eclampsia, obstructed labour, haemorrhage, or puerperal or post-abortal sepsis. The fact that these have become rarities in the industrialized world, in some developing countries and in all but some rural areas of China, proves conclusively that we know enough to act now. What of the means, the resources? Could they be made available? Let me emphasize that we are not speaking of building great hospitals or whole new medical schools. We are speaking of resources which already exist in most developing countries, but not in adequate quantity. We are talking about training more midwives, traditional or otherwise; about extending and strengthening at district and sub-district level the primary health care system for the provision of good prenatal care and family planning service. We are speaking about up-grading ditrict hospitals and rural maternity centres so that they can perform at least the most essential life-saving functions in midwifery and obstetric care. Where new hospitals are needed, it will be these modest units, and not great urban disease palaces which are so costly to build and maintain. I do believe that even in our present wintry economic climate these kinds of modest resources can be made available and deployed effectively, through a combined effort of central and district governments. of international and bilateral agencies, of non-government organizations, and of the communities and families themselves. What we are speaking of is not some kind of supra-national campaign, bu an *initiative*; the beginning of a renewed emphasis and more intense effort to make pregnancy and childbirth as safe for all women in the future as it is for the minority today. This will be an initiative for some of the most vital elements of Primary Health Care, as part of national Health For All strategies. It is an international initiative for what I am convinced can become a long-term, salf-sustaining part of national development. *It could* be done; it *ought* to be done; and in the name of social justice and human solidarity, it *must* be done.