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Maternal mortality

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Magdalena Ohaja and Jo Murphy-Lawless highlight the complexities in sub-Saharan Africa

The reasons that lie behind each woman's death in pregnancy and birth are unique, yet they add up to a distressing picture of maternal mortality which is very complex with overlapping social, economic and political factors at the heart of the matter. Women in sub- Saharan Africa (SSA) face exceptional challenges in this regard and the poorer and more marginalised they are, the more difficult it is for a woman to enjoy good health to begin with and for her to hope that because she is healthy, childbirth will be straightforward and uncomplicated.

The WHO tells us that the immediate physical (medical) causes for maternal mortality break down into the following categories: abortion (7.9%), embolism (3.2%), haemorrhage (27.1%), hypertension (14%), sepsis (10.7%), other direct cause (9.6%) and indirect causes (27.5%).[1]

For women in sub-Saharan Africa the statistics are broken down as follows: abortion (9.6%), embolism (2.1%), haemorrhage (24.5%), hypertension (16.9%), sepsis (10.3%), other direct causes (9.0%) and indirect causes (28.6%).[1]

These figures vary in different countries. Unfortunately, 62% of all maternal deaths occur in SSA alone, where the lifetime risk of maternal mortality is 1 in 38.2 The painfully slow movement in reducing these figures over the last fourteen years since the Millennium Goals on maternal health were devised is deeply troubling for women, their families and communities who are poorly supported and for whom the lack of care has such grave consequences. For midwives, including those who are informally trained and without whom women would be even more poorly supported, the everyday circumstances of pregnant women fill them with dismay. If midwives work in formal healthcare settings, they themselves are unsupported. Regional and national health policy planners seem unable to overcome major care deficits in their systems.

All of the above are working against a background of growing global inequalities with a specific impact on health inequalities. These are a result of the combined impacts of brutally uneven outcomes in respect of how economic globalisation has evolved, of climate change, and of austerity policies imposed since the international financial crisis of 2007, all of which have targeted the poorest and most vulnerable. Global Health Watch (GHW), the organisation which exists to help activists to exchange case studies and experiences internationally, with an emphasis on practical interventions at local and national levels, lays out this detail. Importantly GHW also attempts to develop the theoretical analyses to strengthen our

understandings about how we can have greater and more effective impact in giving people genuine collective agency. In its 2011 report, GHW describes the global economy as a systemic failure with an unworkable '*economic architecture*'.3

In relation to maternal mortality, GHW argues that the challenges are to reach priorities 'according to the objective and subjective definitions of women's needs, and to make these priorities a part of a larger development programme. 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. This raises a critical question about the classification of the causes of maternal mortality. 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 about maternal mortality.'4

GHW plead for attention to be focused on a huge range of underlying issues: food security, poverty, the inadequacies of public systems and public governance in countries of the south in dealing with basic healthcare, women's needs for land rights, basic minimum wages and safety from atrocities. These core issues, rather than what it terms any '*superficial intervention strategy*', are what must be comprehensively responded to in order to make a difference. As matters stand, there is a persistent disconnection between global health policies, which primarily focus on how to address the physical causes of maternal mortality (as outlined above), and these entrenched and worsening local complexities.

Given the fact that recorded progress is not sufficient to achieve Millennium Development Goal 5 (MDG5) in 2015 as planned,2 local realities must therefore be key to solutions as distinct from western imported strategies, if we are to witness substantial improvements in achieving reductions in maternal deaths post 2015. By this we mean that maternal health strategies should begin to tackle the issues outlined by GHW as a matter of urgency. Also as deliberations are ongoing across the world about strategies to improve MDG5 and its sustainability post 2015, one would hope that those whose lives it touches most will be included and not be forced to remain voiceless. It is no longer acceptable for women, particularly those in the most affected area, SSA, to be relegated to the role of spectators when issues about their well-being are discussed,5 and it is crucial to pay astute attention to the non-clinical aspects of maternal healthcare, place of care notwithstanding.

References

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