# Maternal Health

## MATERNAL MORTALITY—A NEGLECTED TRAGEDY
### Where is the M in MCH?

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### INTRODUCTION

THE World Health Organisation (WHO) estimates that 500 000 women in developing countries die every year from complications of pregnancy, abortion attempts, and childbirth.[1] 100–300 maternal deaths per 100 000 births are common in the Third World, and rates are much higher in rural areas.[2] In contrast developed countries have only 7–15 maternal deaths per 100 000 live births. Morbidity rates are rarely available, but it is certain that for every woman who dies many more have serious, often long-term, complications. Most of the deaths are preventable, yet little is being done to reduce this source of unnecessary suffering and death. Although in recent years much attention has been given to "maternal and child health" (MCH), scrutiny of MCH programmes shows that most of them will do little to reduce maternal mortality. It is difficult to understand why maternal mortality receives so little serious attention from health professionals, policy makers, and politicians. The world's obstetricians are particularly neglectful of their duty in this regard. Instead of drawing attention to the problem and lobbying for major programmes and changes in priorities, most obstetricians concentrate on subspecialties that puts emphasis on high technology. By reviewing the issue here we hope to stimulate those concerned with international health and doctors and policy makers in developing countries to make reduction of maternal mortality one of their priorities.

### TRENDS IN THIRD WORLD MEDICAL CARE

Medical services in most Third World countries usually have been patterned on Western systems of medical care.[3–5] These systems concentrate on urban medical centres, curative treatment provided by highly trained personnel (principally physicians), and modern technology. Halfdan Mahler, WHO Director General, has called such centres "disease palaces".[6] They consume a large portion of a poor nation's health budget, yet serve only a minute portion of its people. A large proportion of the population in developing countries live in rural areas; it ranges from 40% in parts of Latin America to 90% in parts of Africa and Asia. There are generally logistic or financial barriers to rural people using the urban hospitals effectively. Consequently, it can be argued that in many rural areas the delivery of services (sometimes modern in nature) by traditional practitioners and the over-the-counter availability of antibiotics and other medicines in village stores, along with changes in sanitation and nutrition, have done more to reduce death rates than has the formal medical system.[3]

Although the British had initiated several relevant approaches to rural health care in their colonies—namely, by training various types of health care personnel to deliver some of the care[5,7]—when national independence was achieved, the trend was to abandon such innovations and to build hospitals and medical centres in the capital cities, often with help from international donors.[7] During the past 15 years, however, more attention has been paid to tailoring medical systems to the needs and resources of developing countries. A major expression of this reorientation is the increased interest in primary health care (PHC), which was adopted as a global strategy for health at the Alma Ata conference in 1978.[8]

PHC concentrates on preventive care and management of the infections and nutritional deficiencies among children so common and devastating in poor countries. Moreover, PHC relies on the use of available personnel, including auxiliary health workers, villagers, and traditional health practitioners, and the small force of highly trained personnel is reserved for complicated tasks. Such an approach is necessary since in many rural areas of the Third World there are about 100 000 people per physician, compared with 1000 or less in the West and in many capital cities of developing countries.[9] This approach has even been adopted in developed countries, where various members of the health-care team have been given new responsibilities. There can be no doubt that the move away from Western medical models and towards PHC is a major improvement. However, there are some important health problems on which PHC (as currently defined) will have little impact. One of these is maternal mortality.

### MATERNAL MORTALITY IN THE THIRD WORLD

Even in the United States today, official statistics on maternal mortality are thought to underestimate incidence by 20–30%.[10] In developing countries the inaccuracies are much greater. For example, in 1978 the Egyptian government reported a national rate of 82 maternal deaths per 100 000 live-births.[11] In 1980–82, however, a well-designed community study in a wealthy area of Egypt found a maternal mortality rate of twice that—190 per 100 000 (ref 12 and Fortney JA, Rogers SM, personal communication). Perfect data, though, are not essential for formulating health policies and programmes. For example, according to WHO, maternal mortality rates in Africa range from 160 to 1100 deaths per 100 000 births.[2] Even if the true figure is near the lower end of this range, say 200–400, it is still unacceptably high. Another indication of the magnitude of the problem is that about 25% of all deaths among women aged 15–49 in developing countries are maternal deaths, compared with less than 1% in the United States.[12–14]

### WHERE IS THE M IN MCH?

In discussions of MCH it is commonly assumed that whatever is good for the child is good for the mother. However, not only are the causes of maternal death quite different from those of child death but so are the potential remedies.

The major causes of illness and death among young children in the Third World are diarrhoeal and other infectious diseases (such as measles and pneumonia) and malnutrition. To reduce mortality among infants and young children in developing countries, national and international agencies are promoting several relatively simple preventive measures, including oral rehydration, growth monitoring, breastfeeding, and immunisation. Other components of what has come to be recognised as the basic MCH package are food supplementation in cases of malnutrition, and family planning. Only one of these services can substantially reduce maternal mortality—and that is family planning.