MATERNAL MORTALITY : CAUSES BEHIND THE CAUSES

DAKSHA D. PANDIT • N. P. PAI

SUMMARY

Today, the rates of maternal mortality in rich and poor countries show a greater disparity than any other public health indicator. Thus, for a women in the developing world, the average life time risk of dying of a pregnancy related cause is between 1 in 15 to 1 in 50, compared with average life time risk of between 1 in 4000 to 1 in 10,000 for a women in the developed world (Royston 1989). The fact that the richest sources of information about maternal mortality are hospitals, means that the focus of attention has been on its biomedical and clinical causes rather than on its socio-cultural context. This paper deals with various socio-cultural causes which often precede the medical causes and make childbirth a risky venture. They could be called the "Causes behind the causes".

INTRODUCTION

In our country, there are about 500 maternal deaths for every 100,000 livebirths as compared to 7 in United Kingdom, 9 in U.S.A. and 4 in Denmark (Central Bureau of Health Intelligence 1987). It has been estimated that in India, for every maternal death there are atleast 20 mothers who suffer from impaired health and efficiency (Park and Park 1985). The poor maternal status compromises maternal health in many ways. There is now a pressing need to establish the relationship between the status of women and maternal mortality. The socio-cultural and logistic factors often precede the medical causes and make childbirth a risky venture.

Too early, too many, too late and too close pregnancies together, affect the mother's health and have its roots in the social status of woman. Contrary to the popular belief that childbirth gets easier with each experience of it, the risks involved in repeated child bearing are many. Repeated pregnancies and breast feeding make big nutritional demands that women from poor houses are seldom able to meet. It is estimated that half of the nonpregnant women and almost two-thirds of pregnant women are anaemic in South East Asia (Winikoff 1988). Anaemia increased the danger from haemorrhage and other complications in childbirth. The important question as far a social causes of maternal death are concerned is why women bear many children inspite of the

Dept. of P.S.>M. Topiwala Medical College, Bombay.
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costs to their health. Many women believe it to be in their own interest for variety of reasons. In many societies, a woman's only path to social status and personal achievements is through motherhood. The other reasons are children prove a woman's worth, prove husbands virility, son preference, children as labour, security in old age, survival of children and family size and teenage marriage (Royston 1989).

Teenage marriage which is reflection of the low status of women is another social customs following high fertility in India. It is a crucial factor in maternal mortality of the number of years of childbearing a head of the youngbridge and because of particular risks she runs in giving birth before she is fully mature. There is gradual rise in age at marriage in our country (Table I). As per 1981 census the average age at marraige in females is 18.6 but in some states still a substantial proportion of marriages continue to take place before 18 years inspite of having child marriage restraint act (Park & Park 1985).

Education is an important key to the improvement of status. There is also an abudance of research which points to the possibility that rising levels of education results in lower fertility. Fairly important strides in the matter of female literacy and education have taken place in India since independence (Table II). It is observed that female literacy rate as per 1981 census is 24.88 which is almost half of the male literacy rate (U.N. 1981). It is observed that age specific enrolment ratios in the age group 11 - 14 years is only 31.57% in girls and 54.44% in case of boys (U.N.F.P.A. 1985). It is indeed probable that lack of mother's perception of the value of education, inhibits her willingness to sacrifice for the educations of her daughter. A study undertaken by the Planning Commission covering 16 states gave four main reasons why most girls do not attend the school system (U.N. 1982). Financial difficulties, preoccupied with household chores, lpre-occupied with care of younger children engaged in economic activity within or outisde the household to supplement income are the reasons for not attending school. It is clear that womenwith education are more likely to marry later, delay child bearing, use family planning, seek prenatal care, use obstetric services and avoid harmful tradtional practices regarding pregnancy and childbearing. As far as maternal death is concerned, the evidence is that education plays a powerful role in reducing maternal deaths.

The link between the general health status of woman and maternal mortality is clear. Woman's health is conditioned to a great extent to social attitudes and woman's status in society. Many of the health problems that affect woman have their roots in childhood. Sex discrimination acts on the health of the woman in numbr of ways. Son perference goes hand in hand with neglect of daughters. Female children suffer additional health problems due to unequal allocation of household resources. In many societies girls are given less of a share of the family food, of family resources and of other goods such as education. This has been brought out by various studies.

It is also observed that females experience excess mortality in childhood which runs counter to the basic biological tendencies. The mortality rates according to the sex of the child as per the Unicef report (Table III) brings out clearly the higher female mortality except in the first week or month of life-contrary to the developed countries, where male mortality is higher throughout life, resulting in lower life expectancy for the male (Ghosh 1986). Increased female mortality in childhood has been sharp enough to lower life expectancy of women despite their natural propensity to outlive ment (Table IV).

The steadily declining sex ratio of females to males, in India over the last 100 years, particularly since the beginning of the current century has been the subject of much speculation and investigation. Declining sex ratio also points to the excess female mortality (Table V).

Another factor is equation of female health and survival is the number of hours a woman must work each day. During the UN" decade for

TABLE I

Average age at marriage

Year	Men	Women
Prior to 1951	20.0	13.0
1951-55	21.3	14.3
1956-60	21.2	15.1
1661-65	22.3	16.3
1971	22.6	17.7
1981	23.4	18.6

TABLE II

Percentage of literacy in India (1901-1981)

Year	Male	Female
1901	9.83	0.60
1911	10.56	1.05
1921	12.21	1.81
1931	15.59	2.93
1941	24.90	7.30
1951	24.95	7.93
1961	34.44	12.95
1971	39.45	18.69
1981	46.74	24.88

Registrar General and Census Commissioner (1981)

TABLE III

Sexwise Mortality rates

	Male	Female
Perinatal	70	60
Nenonatal		
Early	44	41
Late	30	35
Post neonatal	58	72
Upto 1 year	132	148
1-4 years	7.6	8.1
5-14 years	1.3	1.3

UNICEF Report 1984

TABLE IV

Expectation of Life at birth-India

Year	Male	Female
1901	23.63	23.96
1911	22.59	23.31
1921	19.42	20.91
1931	26.91	26.56
1941	32.09	31.37
1951	32.45	31.66
1961	41.89	40.55
1971	46.40	44.70
1980	54.1	54.7
1985	57	56

Govt. of India; Health Information of India (1986)

TABLE V

Sex ratio in India

Year	Females per 1000 males
1901	972
1911	964
1921	955
1931	950
1941	945
1951	946
1961	941
1971	930
1980	933

Govt. of India; Health Information of India (1986)

women!" attention was drawn to the fact that nearly everywhere women are bearing a double burden. So much of their outside labour is unpaid and therfore "invisible". Women are rarely relieved of any of their house-keeping responsibilities by their menfolk.

The status of women affect their general health in many direct and indirect ways. But what is the picture of health care for women ? How responsive is to their needs and how well do they use services that are available ? As a result of poor health and lack of appropriate medical services (including access to safe means of fertility control) women bear an enormous risk every time they become pregnant. Access to maternity care is poor. Only 41% of pregnant mothers in our country have access to maternity care. In India only 33% of deliveries are conducted by trained personnel and only 47% of pregnant mothers have been reported to be immunised against tetanus during 1983-1987 (Kapil 1990). The low coverage to tetanus toxoid immunisation reflects the poor quality of antenatal services. Shortage of staff, inadequately trained staff, lack of supervision, lack of transport facilities, lack of essential equipment at clinic, lack of emergency obstetric care, under utilization of MCH services are the factors which affect maternal health in many ways. This is partly due to woeful inadequacies in provision, when on an average 3.7% of gross national product is spent on health services with the result that many million mothers live beyond reach of modern medicine (Kapil 1990).

Thus the low status of woman is self perpetuating. It will need enormous political will to break the cycle. For many women death in childbirth is the final devastating signal of their low status. Addressing "Causes behind the causes" is absolutely vital in any attempt to control maternal mortality. However, measures to improve social conditions for women must never be considered an alternative to professional maternity care but rather as complementing it. Though pregnancy is essentially a healthy process, unexpected complications occur even in most healthy social environments, and at this point efficient medical services are absolutely necessary to save lives.

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