MATERNAL MORTALITY: AN INQUIRY INTO THE CAUSES AND CONSEQUENCES

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Abstract

Maternal deaths prevalent in most developing countries result from certain complications that ore preventable. Though accurate statistics are not available in these regions, the situation is compounded by complications and deaths of women who choose to deliver at home for certain religious or cultural reasons. Low level of educational attainment by the women, poor medical facilities, ignorance and poverty are oilier precipitating factors. Conscious efforts on the part of the individual women, family members and community at large are needed to stem this high death rate. Towards this end, enlightenment campaign in motor parks, markets, churches and schools is urgently needed. At the university level, family life education should be made part of the general studies programmes

Introduction

In most developing countries, thousands of women die each year during childbirth and pregnancy related complications. Some others suffer permanent injuries or disability, in situations where such sufferings and death are preventable. In Africa, about 600 mothers' death is estimated in every 100,000 live births. In Asia and Latin America, the estimate is 400 and 300 deaths respectively (Royston & Lopez, 1987). These figures become higher among rural populations where all the social and medical services are in short supply. What appears to compound the problem is that these figures are often not available, partly due to the level of development. In other words, there may be so many unreported cases of maternal death (Walker et al, 1986), especially where most deliveries are done at home and deaths are not reported appropriately.

Why do we have so many maternal deaths in these regions? Although causes of death vary with each death, what we are sure is that poor and inadequate health services in these regions multiply pregnancy related risks. Abortion related deaths, high birth rates per woman; under age marriage and pregnancy, shortage of family planning services are other factors capable of increasing the rate at which women die in their reproductive years.

To reduce this high maternal mortality rate, most developing assistance organizations have expanded their activities to women to make motherhood safer. Technical and financial assistance have been given, especially in developing countries to reduce this ugly trend. In 1987, the *World Health Organization* (WHO) was so disturbed about this high rate of maternal deaths that it established the safe motherhood initiative to find short-term operations research on maternal health measures. In line with this initiative, governments, universities, non-governmental organizations were encouraged to research into safer motherhood to be sponsored by the World Health Organization (WHO), The World Bank, United States Agency for International Development (USAID) and many other private foundations such as Carnegie corporation, Ford Foundation, Rockefeller Foundation and many others have contributed financially and technically towards reducing the rate of maternal deaths in our communities. All these efforts appear not to have fulfilled the needs of individuals and families as they still lose their mothers and wives to complication arising from childbirths.

This work therefore attempts to review the main causes of maternal deaths both biological and socio-economic, identify who and who are at risk and when, how to identify some symptoms at the "level of pregnancy, delivery or labour and after birth. It will also attempt to find out what should be done by the individuals, families and communities in stemming this ugly phenomenon. It will take a look at the consequences of these maternal deaths on the family and society at large.

Cause of Maternal Deaths

The major causes of maternal deaths are either socio-economic or biological. The biological factors are further categorized into direct and indirect causes:

Direct Causes

1) Hemorrhage

Hemorrhage is one of the causes of death to women. It is common during abortion, prolonged labour, uterine rupture, tears in the cervix or vagina or abnormal position of the placenta immediately after delivery. If not controlled quickly it could lead to death in women (Zhang and Zing, 1988).

2) Infection

Infection is another common cause of death. Post Partum Upper genital tract infection when not well treated may lead to pelvic inflammatory diseases, ectopic pregnancy, infertility and chronic pelvic pains (WHO, 1987). The rate of infection increases with prolonged labour or membrane rupture long before delivery. Sexually transmitted diseases (STDs) could also be a source of infection in women.

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3)**Eelampsia and Preeclampsia**

Preeclampsia is a kind of sudden attack of illness or fits experienced by women especially in first pregnancies. It is a poorly understood health complications .It leads to high blood pressure, fluid retention and presence of protein in urine. If not checked it may lead to eclampsia, a more complicated attack leading to convulsion similar to epileptic attacks. This advanced stage leads to very high blood pressure and cerebral hemorrhage. Those who survive this may suffer from paralysis, blindness or chronic hypertension and kidney damage (Pritchard and Macdonald, 1980).

4) Prolonged Labour

Blood loss, dehydration or metabolic disturbances through prolonged labour can lead to death. This could result from ruptured uterus. Prolonged labour may result when the woman's pelvis is too small due to poor nutrition in childhood or due to underage pregnancy. It could be a product of abnormalities caused by female circumcision.

5) Illegal Abortion

This could lead to complications, infections or hemorrhage, severe illness and death sometimes occur (Megafu, 1 985).

6) Ectopic Pregnancy

This is the implantation of a fertilized egg outside the uterus It can cause life-threatening hemorrhage.

The indirect causes include death of women through viral hepatitis, anemia and cardiovascular disease. They are conditions, which worsen or prove fatal during pregnancy especially in developing countries of the world.

Social and Economic Causes

Most women all over the world have low social status compared to the men. This has consequences on their conditions of living and the health care they receive. They receive less education than men, receive Jess food and health care even in emergency situations and most often permission must he sort from men. They are often made to marry and bear children early and some suffer from female genital mutilations related complications.

family planning services are not available to most women in developing countries. When such services are available, they need the consent of the husbands to adopt them. Family planning is necessary for women because it reduces pregnancy risks associated with under age, too many births and unsafe abortion. Sexually transmitted diseases not well treated before pregnancy can cause complications such as ectopic pregnancy, spontaneous abortion, and premature onset of labour and post part urn infection that can cause death in women.

All these problems and what can be done can be related to the three phases of birth-pregnancy, labour or delivery and after birth.

Pregnancy

In pregnancy, some of the signs of the above listed complications are stated below:

(a) Bleeding from the vagina (ante partum hemorrhage).
(b) Unusually heard or smelling vaginal discharge.
(c) Bad headaches, dizziness, trouble breathing and fatigue.
(d) Swollen hands and face.
(e) Fits (eclampsia).
(f) No sign of labour more than 24 hours after waters break (premature rapture of the membranes).
(g) Protein in urine.
(h) Rising blood pressure.
(i) Still fetus-(Population Reports, 1988).

The lives of many women will be saved if these complications are screened, identified and treated early.

Though it might be the duty of the women to monitor some of these changes, the family members and the larger society have a duty to care for pregnant women especially where such women, have low level of educational attainment. The financial implication of such tests and care should not be left for the woman alone and the community is duty bound to provide the facilities for such care.

Pregnant women must contact health worker as early as possible for screening. This enables health worker to know the reproductive histories, weight and height, immunization undertaken by the women, cases of sexually transmitted diseases, etc. This gives the opportunities to solve some problems early. The women therefore need prenatal education to help them achieve safe pregnancy. It is possible to establish programmes that can help solve many of these problems by improving the quality of services by bringing services closer to women even in their homes, by making them less intimidating, by educating families and communities about prenatal care and by integrating modern with traditional pre natal care.

Labour and Delivery

More women die during labour or delivery, especially in the developing countries. The care women receive during labour and delivery often determines their survival rate: Good care reduces or eliminates post partum infections and prevents many deaths arising from complications in time of labour and delivery. Time is more problematic in communities where birth takes place at home or with traditional birth attendants (TBAs). This situation is compounded by the fact that most countries lack good clinics and hospitals for delivery. Some other women either due to religious consideration or fear prefer to deliver at home even when some facilities are available. This is why some researchers believe that co-operation between traditional and modern health care system is necessary.

Some symptoms of problems at this stage are:

1} Labour lasting more than 24 hours.
2) Fits (eclampsia).
3) Gushing of blood from the vagina (hemorrhage).
4) Umbilical cords hanging in the vagina (prolapsed cord).
5) Foetus not in the usual head-down position (Population Report, 1988).

Some women do not have these problems and give birth without any complications. Even at this, the women still need to be assisted all the way. They should be helped to feel as comfortable as possible, physically assisted during birth, having women breastfeed after delivery, (breastfeeding induces contraction that prevents hemorrhage) providing clean environment and sterilized instrument to avoid infections and protect her from painful or harmful practices.

At other times, prenatal screening may identify a woman likely to develop complications during labour, such women are quickly referred to more advanced centers with better facilities and personnel before labour begins i.e. if the health center does not have the facilities to help the woman.

After Delivery

Maternal deaths can be experienced even after delivery. Some of the symptoms of risks after delivery are:

1. Bleeding lasting for days.
2. Unusually heavy or smelly vagina discharge.
3. Fits.
4. Chills and fever.
5. Pains in the abdomen.
6. Retained placenta.
7. Sore or swollen breast (Population Report, 1988).

Many of these problems are easily detectable immediately after delivery or within the first week after delivery. A visit to the clinic within this is advisable. This first week visit is the ideal period to discuss issues of family planning, breast-feeding and nutrition. The counselling and education usually take the health of the mother and child into consideration. Later visits are also necessary, as it will offer the health care practitioners opportunity to examine the women's uterus and vagina for signs of infection, retained placenta fragments or discuss child immunization and family planning.

Consequences of Maternal Deaths

Maternal deaths have some consequences on the family and society at large. The high rate of maternal deaths induces fear of pregnancy and birth on other married women who are still in their reproductive years. This fear could lead to miscarriage, frigidity in women and infertility. The unchecked pregnancy complications could lead to disability when such women survives such difficult conditions. It could create problems for the children left behind by the women, as other family members may not be able to completely fill the vacuum left by the dead mother. The husband may experience emotional loss and often forced to devote more time for the wellbeing of the children. This may adversely affect his output both socially and economically. The family and community stand to loss from the death of any productive member, especially women.

Conclusion

The foregoing revealed that death of women is mostly related to pregnancy related complications. The causes of deaths have been identified and divided into the three main phases -during pregnancy, during labour or delivery or alter birth or delivery. The consequences are also numerous taking a tow on the family members and society at large. To avoid this misfortune the monitoring and screening must not be left for the individual women, family members and the communities all have a stake in reducing maternal deaths. It will not be feasible to stop women from child bearing as the society will go into extinction. What is therefore encouraged is to make child bearing safer. To do this, women, family members and communities need education which can help improve the status of women, increase age at marriage and make women more aware of their own health needs. We also need to encourage family planning since it helps avoid dangerous pregnancies. The men must be integrated into the family planning activities and make the services more assessable. Such education may reduce underage marriage and pregnancies and ensure that women are fully matured before contemplating pregnancy. Males and females should be given the very basic information about pregnancy and child bearing while health officials must be trained to attend delivery either in clinics or hospitals. Since most educated women are still ignorant of what is needed of them during pregnancy, it is suggested that family life education be made part of general studies programme in our universities.

Since most women do not attend clinics or hospitals for religious or other cultural reasons, traditional birth attendants must be trained. This will mean that both the modern and traditional health care systems will start to experience some forms of co-operation and integrations. On the whole, prenatal screening and monitoring is very essential not only at the level of the individuals but also at the family and societal levels. The essence is to make childbearing healthier, safer and happier.

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