Deaf to the screams

Hundreds of thousands of women are dying every year in pregnancy and childbirth - and nobody wants to know. The NI'S founding editor, Peter Adamson, raises the roof on a monumental conspiracy of silence.

This is a story of unimaginable suffering. And it is a story that will be inadequately told. For no-one who has not experienced what is meant by maternal mortality and morbidity can know the suffering implied. And those who do know are usually silenced by their early deaths, by their poverty, by their gender, and by the insulating layers of censorship and embarrassment that still surround the issues of sex, blood and birth in most societies of the world.

For a decade the figure of 500,000 maternal deaths a year has been part of the statistical liturgy. In 1996 new estimates are showing that the number of women who die each year in pregnancy and childbirth is probably closer to 600,000.

But before the new estimates replace the old as a way of packaging up the problem, it should be said that a mistake has been made in allowing statistics such as these to slip into easy usage. For these are not deaths like other deaths, and death is only a part of the story they have to tell.

They die, these hundreds of thousands of women whose lives come to an end in their teens and twenties and thirties, in ways that set them apart from the normal run of human experience.

Over 200,000 die of haemorrhaging, violently pumping blood onto the floor of bus or bullock cart or blood-soaked stretcher as their families and friends search in vain for help.

About 75,000 more die from attempting to abort their pregnancy themselves. Some will take drugs or submit to violent massage. Alone or assisted, many choose to insert a sharp object a straightened coat-hanger, a knitting-needle, or a sharpened stick through the vagina into the uterus. Some 50,000 women and girls attempt such procedures every day. Most survive, though often with crippling discomfort, pelvic inflammatory disease, and a continuing foul discharge. And some do not survive: with punctured uterus and infected wound, they die in pain and alone, bleeding and frightened and ashamed.

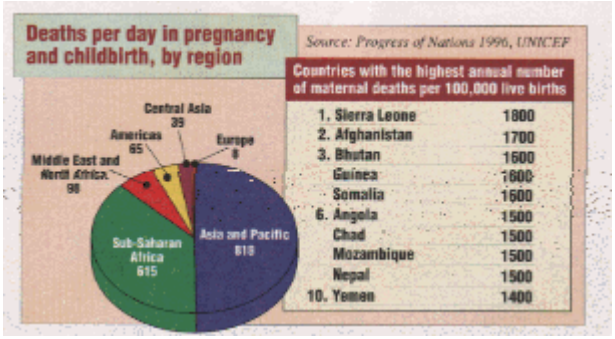
Perhaps 75,000 more die with brain and kidney damage in the convulsions of *eclampsia*, a dangerous condition that can arise in late pregnancy and has been described by a survivor as 'the worst feeling in the world that can possibly be imagined'.

Another 100,000 die of *sepsis*, the bloodstream poisoned by a rising infection from an unhealed uterus or from retained pieces of placenta, bringing fever and hallucinations and appalling pain.

Smaller but still significant numbers die of an anaemia so severe that the muscles of the heart fail. And as many as 40,000 a year die of obstructed labour days of futile contractions repeatedly grinding down the skull of an already asphyxiated baby onto the soft tissues of a pelvis that is just too small.

In the 1990s so far, three million young women have died in one or more of these ways. And they continue to die at the rate of 1,600 every day, yesterday and today and tomorrow.

For the most part, these are the deaths not of the ill or of the very old or of the very young, but of healthy women in the prime of their lives upon whom both young and old may depend.



But the numbers of the dead alone do not reveal the full scale of this tragedy. For every woman who dies, approximately 30 more incur injuries, infections, and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong.

It is part of the silence that has for so long surrounded the issue of maternal morbidity that there is so little research into its prevalence. But based on a few studies and many assumptions, the best estimate that can be made puts the ratio of injuries to deaths at about 30 to 1.

This means that at least 12 million women a year sustain the kind of damage in pregnancy and childbirth that will have a profound effect on their lives. And even allowing for the fact that some women will suffer such injuries more than once during their child-bearing years, the cumulative total of those affected can be conservatively estimated at some 300 million, or more than a quarter of the adult women now alive in the developing world.

It is therefore no exaggeration to say that the issue of maternal mortality and morbidity, locked fast in its conspiracy of silence, is in scale and severity the most neglected tragedy of our times.

Excluded from the home

Many of the injuries sustained during pregnancy and childbirth are distressingly obvious. Rupture of the uterus, prolapse, pelvic inflammatory disease and lower genital tract injuries, make life miserable for millions.[1]

Most obvious and distressing of all is *fistula*. Fistula occurs when the tissues of the birth canal are deadened by prolonged labour and days of pressure from the baby's skull. In the days and weeks after the birth, the dead tissue falls away, leaving holes which allow leakage from the bladder and rectum, or both, into the vagina. Urine and faeces now bypass the muscles that normally control the flow. She is incontinent. And without an operation to repair the fistula, she will remain so all her life. Special clothing is not available. She must make do with cloths and rags which quickly become soaked and soiled. The constant leaking abrades the skin of the genital area and produces a permanent and painful rash. Washing is difficult. Frequent bathing is impossible.

Soon, the woman is excluded from her husband's bed, and then from his home. Living in an outhouse or animal shed, she cannot visit anyone or travel anywhere except by walking. Each year, unknown numbers decide that suicide is preferable to such a life.

The best available estimates suggest that perhaps 80,000 women develop fistula every year. Most cases go untreated, and somewhere between 500,000 and a million women are now living with the problem.

Other conditions can be more successfully hidden, at least at first. Most hidden of all are the long-term effects of the haemorrhages that are suffered by an estimated 14 million women every year. Half of those women, it may be assumed, were already anaemic. But a haemorrhage in childbirth, or in repeated childbirths, can push women further and further down the anaemia road, slowly lowering the quality of life for uncounted millions, making every task an unwelcome effort, every day a day of drudgery, leaving no energy even for the common enjoyments of life.

For a smaller percentage of women, the trauma of haemorrhage brings something worse than anaemia. Those who experience *hypopituitarism*, or Sheehan's syndrome, almost always assume that they are suffering only from temporary tiredness. But as the months pass, the tiredness becomes a chronic weakness, a listlessness stirred by alarm as other symptoms begin to appear the cessation of monthly periods, the loss of pubic hair, an increasing confusion and forgetfulness. Without knowing what is wrong, such women grow old while still young. And eventually their alarm will give way to the cruellest symptom the deepening apathy which makes it unlikely that treatment will ever be sought.

To the extent that Sheehan's syndrome is known at all, it is assumed to be a rare condition. For obvious reasons, definitions are shadowy and figures vague, but recent estimates suggest that Sheehan's overtakes the lives of 100,000 women a year, and may currently affect a total of over three million.

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Further still into the realms of the unreported lies *dyspareunia* the pain that some women suffer during sexual intercourse.

After childbirth, a woman is bruised and battered and needs time to recuperate. Many

will also have suffered specific injuries, often including the tearing or the surgical cutting of the vagina. But in many societies, and in many millions of individual cases, women have no choice but to resume sexual relations within two or three days, regardless of the pain it causes. Pain during intercourse may last for up to a year after a birth. It may also be so severe that a woman lives in dread of having sex. Few can count on sympathy or support and many endure anger, rejection and violence.

Once again, this problem of unknown extent is made worse by the silence that surrounds it. Yet the truth is that it is just one more abuse in a lifetime of abuses that are linked, in one way or another, to the different ways in which different societies make a woman suffer for her reproductive role.

As a child, she may endure genital mutilation in order to contain sexuality and protect marriageability. As a menstruating girl she may be set aside as unclean, polluting and made to feel dirty and ashamed. As a teenager she may be married to someone she does not know, and made pregnant before her own body is fully grown.[2] As a woman unable to bear children she may be abused and abandoned, even though it may be the husband who is infertile, or even if her infertility is caused by a sexually-transmitted disease originally contracted by her partner. As a pregnant woman she may be denied the basic consideration, the rest and the food and the antenatal care, to which she is entitled. As a woman in labour she will run the risk of dying from the lack of obstetric care, and of sustaining injuries and disabilities for which she will not receive treatment.

As a woman enduring a prolonged childbirth she may be left to die alone and in agony, the baby asphyxiated inside her, in societies where men interpret obstructed labour as a sign of unfaithfulness. As a woman suffering from a childbirth injury, from a still-open artery or a ruptured uterus, she may die because her husband will not allow her to be seen by a male doctor. As the mother of a baby girl she may be blamed and beaten despite the fact that it is the chromosomes of the male that determine the sex of the baby. As a wife she may be forced to submit to sex within a few days of giving birth, or subjected to violence if she refuses. As a new mother she may be expected to become pregnant again before her body has recovered. And finally, even if she has sustained an injury or infection that is serious and treatable, and even in those rare cases when health workers seek her out knowing that she will not come to them, she may still not be allowed to go into hospital because there will be no-one to cook the meals.[3]

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How can such a heavy burden of death, disease and disability have continued for so long with so little outcry?

In part, the conspiracy of silence surrounding this issue is a reflection of the fact that women are conditioned not to complain but to cope. No matter the injuries or disabilities they labour under, they will usually continue to look after children, fetch and carry wood and water, go to market, and work long hours in the fields, while hoping that the pain will go away, that the wound will heal, that the discharge will

stop, that they will soon be able to have sex without pain, and that they will one day recover their vitality. And for the most part they cope in silence. They neither ask nor receive a lesser workload, or medical care, or consideration for what they have suffered or the condition they are in.

Ultimately, therefore, little is either said or done about this problem because it is a 'woman's problem', a problem that, by long tradition, most men and most governments do not wish to know about. As one midwife with 25 years' experience of developing countries has put it: 'If hundreds of thousands of men were suffering and dying every year, alone and in fear and in agony, or if millions upon millions of men were being injured and disabled and humiliated, sustaining massive and untreated injuries and wounds to their genitalia, leaving them in constant pain, infertile and incontinent, and in dread of having sex, then we would all have heard about this issue long ago, and something would have been done.[4]

Feminist silence

But there is another, more surprising reason for the failure to break the silence. It might have been expected that the voice of the women's movement would have been raised on behalf of the millions of women who suffer for reasons that are related solely to the fact of being a woman. But with honourable exceptions, this is an issue on which the women's movement in the industrialized nations has raised scarcely more than a murmur. When asked, many of the women who work with maternal death and injuries in the developing world will offer the same explanation: for most Western women, feminism is in large part a fight against the circumscribing of a woman's opportunities by her reproductive role; many who are engaged in that struggle have therefore been reluctant to take on an issue which seems to centre on women as mothers rather than women as women.

The first and most obvious step towards reducing the toll of maternal mortality and morbidity is to make high-quality family-planning services available to all who need them. With today's knowledge, it is possible to do this in ways that are acceptable to all countries and cultures. Meeting only the existing demand for family planning would reduce pregnancies in the developing world by up to a fifth, bringing at least an equivalent reduction in maternal deaths and injuries. Add in the many other benefits of family planning for all fewer abortions, better health and nutrition of women and children, faster progress towards gender equality, slower population growth, reduced environmental pressures and the costs are almost derisory. Yet family planning receives less than two per cent of all government health spending in the developing world, and less than two per cent of all international aid.

The greater challenge is to reduce deaths and injuries in the great majority of cases where the pregnancy is wanted. Some will always fall back on the idea that this must await economic development, and that only when women are healthier, better educated and better nourished will maternal risk be lowered.

But the historical record gives scant support to such complacency. In Britain, for example, there was almost no fall in maternal-mortality rates during the century before 1930 when standards of health, nutrition, education and hygiene were advancing rapidly. Only when skilled midwifery made deliveries cleaner and safer

and modern obstetric care began to cope with obstructed labour, haemorrhage, infection and hypertensive disorders did maternal deaths begin their sharp fall to today's levels. On a smaller scale, these same conclusions have been demonstrated by a study of a sect in the US whose members were relatively prosperous, well nourished, and well educated, but who would not accept modern medical care. The study found that the maternal-mortality rate was approximately 100 times higher than the US average and approximately the same as in rural India.

Faced with this and other evidence that obstetric care is the key, many have argued that the costs of such services are simply too high for the developing world to contemplate. But no developing country is starting from scratch. Even in the largest and poorest nations, there are usually health units and district hospitals with the doctors, midwives, nurses, drugs, and equipment that can provide obstetric care when needed. If they cannot, then this usually reflects a lack of priority, or a lack of relatively small amounts of funds for basic training and equipment, rather than the inherent impossibility of the task. Few figures are available on how many women have access to obstetric care, but in a country like India, informed estimates suggest that perhaps three-quarters of the 125,000 women who die each year in childbirth live within a few kilometres of a health unit or district hospital where emergency care is or should be available. And there is usually enough time for a woman to be transferred to such a facility if danger signs are recognized in time.

Action on this issue has been paralyzed for too long by the idea that only the building of hundreds more hospitals and the training of thousands more expensive obstetricians can make the right kind of care available to the 15 per cent who need it. But the fact is that properly trained health workers and midwives, working in modern health units with inexpensive equipment and reliable supplies of relatively cheap drugs, can usually cope and know when to call in obstetricians if a caesarean section is necessary.

A great deal of confusion has arisen because the terms 'midwife', 'traditional birth attendant' and 'trained birth attendant' are frequently used interchangeably. In particular, much of the argument about what midwives can and cannot be expected to do is born of the failure to distinguish between a formally trained midwife, working with the support of modern health services, and a traditional birth attendant unconnected to obstetric services. Properly qualified midwives and health workers who are used to dealing with such problems will usually cope better than doctors who may encounter such problems only a few times a year.

The world at the close of the twentieth century is guilty of a colossal failure of imagination if it remains deaf to the cries of so many women

The opportunity must be there for every woman who becomes pregnant to be brought in to a health unit or hospital if and when complications occur.[5] Making modern obstetric care more available is no insignificant task. But the financial cost would be only a very small proportion of the $85 billion a year that the governments of the developing world currently spend on their health services, or of the $5 billion a year in international aid that is allocated to those services.

Reducing maternal deaths and injuries is therefore not a matter of possibilities but of priorities. The strategies that work have been identified. And the resources will follow if priority lights the way. What is needed now is a much wider and noisier demand for action in order to force this issue into public consciousness and onto the political agenda. The first task is to break the mould of silence. And there is scarcely a politician, or health professional, or researcher, or journalist, or non-governmental organization, or women's group, or member of the public, that could not play some part in such a movement. In particular, the professional organizations of obstetricians and gynaecologists that exist in almost all countries could say more and do more about the issue. All of these voices are needed to press for government health budgets and international aid programmes that specifically confront the taboo tragedy of maternal deaths and injuries.

Failure to do so, in the face of an issue that has affected so many so severely and for so long, amounts to a tacit complicity with the forces of silence, an acquiescence in the long reign of the idea that these issues should not be spoken about too loudly because they are faintly embarrassing and because, after all, they affect mainly women and mainly the poor.

The statistics alone would be enough to justify the claim to priority of a problem that has affected perhaps 25 per cent of the women now alive and which causes some 585,000 deaths a year.

But there is also a dimension that statistics cannot capture. It is perhaps not possible to give a weighting to the pain and the fear, the undermining of confidence and self-esteem, or the nagging injuries and humiliations and anxieties that are the constant companions of so many women's lives. But the world at the close of the twentieth century is guilty of a colossal failure of imagination if it remains deaf to the cries of so many women who daily live with the sadnesses and sufferings that travel under the name of maternal morbidity.

Aldous Huxley wrote of human suffering: 'Screams of pain and fear go pulsing through the air at the rate of eleven hundred feet per second. After travelling for three seconds they are perfectly inaudible.' It is time to amplify the screams.

Peter Adamson *was the founding editor of* ***New Internationalist*** *and still chairs our Advisory Trustees. He left the* ***NI*** *in 1980 to begin a distinguished career with UNICEF: he was responsible for the annual* ***State of the World's Children*** *report from 1980 to 1995, and for the book* ***Facts for Life****. He also edited* ***The Progress of Nations*** *and this article, which appeared in the 1996 edition, was effectively his UNICEF swansong. He's now taking a break to do some more personal writing.*

1 *Quantifying Reproductive Health Risks: Descriptive Epidemiology of Major Conditions*, CGL Murray and AD Lopez eds (Harvard University Press for WHO and World Bank 1996). 2 Many societies believe that a girl has reached child-bearing age when menstruation begins. But at the onset of menstruation, a girl has about 5 per cent more height to attain but between 10 and 20 per cent more pelvic growth. 3 *The Silent Endurance; Social Conditions of Women's Reproductive Health in Rural Egypt,* AS Khattab Hind/ Gillian Potter, eds (Population Council, UNICEF 1992). 4 Personal communication from Sister Anne Thompson, WHO, November 1995. 5 'Removing Risk from Safe Motherhood', JE Rohde, *International Journal of Gynaecology and Obstetrics*, Vol 50, Suppl 2, 1995