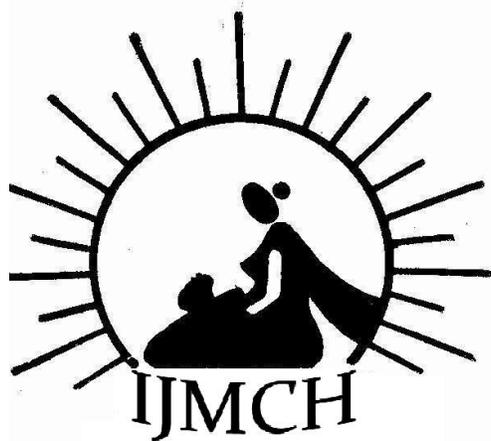


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Developing countries**

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Even in the era of tremendous advancements in the healthcare systems, the mortality rates for the women of reproductive age are significantly high. This is especially evident in the under developed and developing countries.

Maternal Health Safety – Issues and Concerns of the Developing countries

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ABSTRACT

Even in the era of tremendous advancements in the healthcare systems, the mortality rates for the women of reproductive age are significantly high. This is especially evident in the under developed and developing countries. In view of this, the literature published pertaining to the various issues related to women's mortality has been reviewed in this study. The review was carried out by following standard methodology and care was taken that the studies published in the standard journals were used for the purpose of review. The literature clearly indicated that the mortality rate was a function of multiple attributes; prominent amongst them are status of healthcare delivery systems and inadequacy of skilled healthcare professional, lack of awareness of nutritional quality and quantity of food items to be consumed, general hygiene for preventing the different types of diseases and socio-cultural problems. The literature has highlighted the need to integrate different mechanisms for minimizing the mortality rate of women of reproductive age, especially in developing countries.

Keywords: Mortality rate, Women of reproductive age, Skilled healthcare professional, Nutritional quality, Socio-cultural problems

INTRODUCTION

Human Health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity (Constitution of the WHO). However, many people do not realize the importance of good health, and even if they do, they often disregard it. This attitude is particularly visible in the developing countries where the awareness regarding health concerns is very low. Just like the lack of awareness of the health concerns, the important issue of maternal health also receives very less attention.

The maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. Motherhood is often a positive and fulfilling experience; however, for too many women it is associated with suffering, ill-health and at times even death. It is evident from the maternal health statistics that the present situation is very grim as far as less developed and developing countries. Many past studies have reported the causative agents or factors that result in the phenomenon or events of maternal deaths, noteworthy medical amongst them are haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Apart from the medical problems, other problems like, socio-economic condition, cultural obligations, education, awareness, etc. are also responsible for increased risk of the maternal mortality.

Furthermore, not all the factors are critical factors in all the areas, which warrants that regular/periodical or systematic investigations should be carried out to know the various

issues that are related to maternal health in general and maternal mortality in particular. In the backdrop of above information, this study was carried out with an aim to critically review the published literature regarding the maternal mortality.

METHODOLOGY

In view of the aim and objectives of this study, a literature review was carried out to study the previous research efforts. For the purpose of literature review the background considered the aspects on the research question being posed, which included but were not limited to the theoretical background, methodology, previous findings, etc. The reviewed literature was used for synthesizing and gaining a new perspective of the issues concerning the maternal mortality and related issues. The discussion is presented in a chronological order, so that the review also indicates the underlying pattern of evolution of thoughts and ideas in the focused domain.

DISCUSSION

Fauveau et al., (1991) have evaluated the efficacy of a maternity-care programme in the context of the role of primary health-care project in rural Bangladesh and concluded that maternal survival can be improved by the posting of midwives at village level and if they are given proper training, means, supervision, and back-up. Furthermore, Stokoe (1991) has reported that the causes of maternal death related to pregnancy are primarily related to medical, socioeconomic, demographic, and cultural factors and have concluded that the maternal mortality rates can be lowered down by correct and timely intervention. In addition to this Jacobson (1991) has reported that the public health strategy for preventing maternal mortality should put strong emphasis on the regular training aspect in general the training of traditional birth attendants in particular. Sundari (1992) has stated that prevention of maternal deaths requires fundamental changes not only in resource allocation, but in the very structures of health services delivery. Moreover, prevention and control of maternal mortality is dependent on structural factors and women's resources such as their time, money, information they have, and their authority over decision making.

Dutta (1993) had reported that the Health Systems in rural and urban areas are distinctly different and in general the coverage of healthcare systems is uneven and quality of services is poor in rural areas, which has direct effect on the maternal mortality rate. Based on their findings Bhardwaj and Hasan (1993) have concluded that a community approach to health care, improvements in women's education, and grass roots level health personnel can minimize neonatal death rate in rural areas in India. Furthermore, Ibrahim et al., (1994) reported that the risk of an unfavourable outcome (stillbirths or neonatal deaths) in multiple pregnancies was more than ninefold that of singletons and maternal illiteracy was associated with significantly higher risk of neonatal death. Martey et al., (1994) have stated that high mortality rate during delivery is a realistic justification to improve the quality of care during delivery and potential interventions to reduce maternal mortality, include establishing operating facilities at local health centers and maintaining a resident doctor for obstetric emergencies.

Kwast, (1995) has advocated a need to implement norms and protocols, expert supervision and sensitization of hospital staff to the needs of the community to increase referral by traditional birth attendants to the hospital to reduce perinatal mortality. Mturi and Curtis (1995) showed that there is a remarkable lack of infant and child mortality differentials by socioeconomic subgroups of the population, which may reflect post-independence health policy and development strategies. Kwast (1996) has reported that the critical issues concerning the safety of mother are often related to nonmedical reasons and cultural appropriateness.

Kambarami et al., (1997) has reported that factors significantly associated with perinatal mortality were ethnicity, marital status, subjective standard of living and the women's level of formal education. Ronsmans et al., (1997) have reported that a high percentage (more than 72.0%) of maternal deaths were due to direct obstetric causes such as postpartum hemorrhage, induced abortion, eclampsia, dystocia, and postpartum sepsis. Singh & Paul, (1997) have reported that the health pyramid often does not function effectively because of limited resources, communication delays, a lack of commitment on the part of health professionals, and, above all, a lack of managerial skills, supervision, and political will.

Dutt and Srinivasa (1997) have stated that good maternal and child health services can substantially improve child survival in spite of prevailing low socio-economic situations. However, inputs for neonatal care need to be strengthened to further enhance child survival. Wall (1998) has stated that among the most important factors contributing to the maternal mortality situation are: an Islamic culture that undervalues women; a perceived social need for women's reproductive capacities to be under strict male control; the practice of purdah (wife seclusion), which restricts women's access to medical care; almost universal female illiteracy; marriage at an early age and pregnancy often occurring before maternal pelvic growth is complete; a high rate of obstructed labor; directly harmful traditional medical beliefs and practices and inadequate facilities to deal with obstetric emergencies. Van et al., (2003) concluded that many women in rural community suffer the consequences of high pregnancy loss; however, improved education and skilled assistance at delivery can result in improved pregnancy outcome and further reported that proximity of any household to a health centre has an effect on outcomes.

Hankins et al., (2006) have reported that frequency of significant fetal injury is significantly greater with vaginal delivery, especially operative vaginal delivery, than with cesarean section for the non-laboring woman at 39 weeks EGA or near term when early labor has been established. Based on the literature review, authors stated that the clinician's role should be to provide the best evidence-based counseling possible to the pregnant woman and to respect her autonomy and decision-making capabilities when considering route of delivery. Caughey et al., (2009) reported that randomized controlled trials suggest that elective induction of labor at 41 weeks of gestation and beyond is associated with a decreased risk for cesarean delivery and meconium-stained amniotic fluid. Raman et al., (2012) have mentioned that the important risk factors for neonatal mortality risk to emerge are low birth weight, prematurity, young age of mother, older mother and high birth order.

CONCLUSIONS

In the present investigation it was evident that even after tremendous developments in the field of healthcare; the mortality rates are remarkably high. This high mortality rate has been attributed to many different aspects, notable amongst them are inefficiency of healthcare delivery systems, lack of awareness amongst the women of reproductive age group regarding the importance of nutritional quality and quantity of food items to be consumed, inadequate number of skilled healthcare professional, general hygiene for preventing the different types of diseases and socio-cultural problems.

Though all the above mentioned problems are important not all the problems are prevalent in all the areas. This warrants that the measures needed to improve the healthcare systems as well as health of the women of reproductive age can be achieved by identifying or determining the most important/critical factors responsible for mortality in different geographical areas. The literature has highlighted the importance as well as use of different mechanisms as promising measures for minimizing the mortality rate of women of reproductive age, which is depicted in following Table 1.

Table 1: The critical areas observed through the literature review are as follows

Medical problems	Important factors vis-à-vis higher maternal death	Patient factors	Health Services	Other problems	Remedial measures
<ul style="list-style-type: none"> • Anemia • Abortion complications • Postpartum hemorrhage • Postpartum sepsis • Obstructed labor • Eclampsia • Non-medical abortion • Poor delivery management 	<ul style="list-style-type: none"> • Obstructed labor • Malnutrition • Poverty • Overwork • Lack of primary health care • Parasitic disease • neglect to girls and women • Polygamy • Early marriages and childbearing • Underfeeding • Incorrect dietary practices during pregnancy • clandestine abortion 	<ul style="list-style-type: none"> • Delayed arrival at a healthcare facility • Non-arrival at a health facility • Failure to seek legal abortion • Interference with pregnancy • Nonuse of prenatal care • Transportation problems 	<ul style="list-style-type: none"> • Socially accountable • Careful record keeping • Public accessibility of records • Empowerment of the deprived section of society • Participation in the changes 	<ul style="list-style-type: none"> • Low income • Diet related • Economic • Psychological • Socio-cultural • Technical and administrative barriers 	<ul style="list-style-type: none"> • Antenatal care with risk referral • Small family norm • Family planning • Adult education • Training and supervision of traditional birth attendants • Maternity waiting homes • Decentralized maternal-child health care • Provision of legal medical abortion • Blood banks at delivery units • Standardized obstetric care • Compulsory education of girls and later marriage • Uninterrupted medical supplies • Good transportation of supplies • Mobile clinics

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