Maternal Mortality and Abortion in Developing Countries: the Need for a Pro-Life Response

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I am ashamed to admit that I did not entirely appreciate how dangerous childbirth can be for both women and their babies until I became a mother myself. My eldest son, who is now five years old, would not be alive today if it were not for a skilled obstetrics team who delivered him by emergency caesarean, following a lengthy obstructed labour. My youngest child would not be alive today if it were not for skilled midwives and paediatricians who resuscitated him when he stopped breathing, and detected and treated his chest infection in a well-equipped Special Care Baby Unit, manned 24 hours a day by dedicated nurses. And I am aware that I would not be alive today to raise my children if I had not had access to excellent hospital facilities, nurses, midwives and doctors who were able to save my life when I developed complications during two out of three labours. I told somebody after my first baby was born that when, after nearly twenty-four hours of the worst agony I had ever experienced, an obstetrician entered the labour room, I felt as though I were being rescued from a torture chamber. Contrary to the opinions of some of my more acerbic critics, this was not my "fondness for hyperbole" at work: I was in fact demonstrating the great British art of understatement. The obstetrics team at the Rosie Maternity Hospital were not rescuing me from torture; they were rescuing me and my baby from death sentences.

Here in the West I think we can all be in danger of complacency when it comes to maternal health. Very few people in this room, mercifully, will know a woman who has died in childbirth and maternal mortality can feel rather like the stuff of Victorian horror stories. I remember us giggling during A-level English Literature classes over the number of nineteenth century novelists who introduced their heroines with the words "her mother died in childbirth and left her an orphan and a beggar" or over the typical emotional outcry "save the child!" from the mouths of other worthy heroines. But even these Victorian melodramas should be stark reminders that not so long ago in our own history, everyone would have known some woman who had died in childbirth and the tragedy of maternal mortality – of women dying young, of children growing up orphans – remains the reality in many countries of the world. However, whereas in early nineteenth century Britain, there was little that could be done to save a woman facing complications such as sepsis or obstructed labour, there is no reason in 2011 why any woman should die during or as a result of giving birth.

That is the real tragedy. There is no inevitability here. Dr Robert Walley, director of the Canadian-based group of Catholic obstetricians and gynaecologists *MaterCare International* describes maternal mortality rather more accurately as 'an international disgrace'.

Numbers

How many women around the world are dying in childbirth every year? Accurate numbers are very difficult to calculate for a number of reasons. The first is poor reporting in some countries, or indeed, no reporting of maternal death at all. It is notable that developing countries tend to have poor or non-existent mechanisms for recording maternal death[i] - and these are the countries which have the biggest problem with maternal mortality. However, there are also differences in methods of reporting. For example, one country may define a maternal death as a death which occurs up to seven days after birth whereas another

may define it as a death up to 42 days after birth. The generally accepted definition of maternal death is, in fact, death 42 days after birth. Some countries will include only direct causes – sepsis, haemorrhage, obstruction – whereas others will include indirect causes; that is, a condition exacerbated by pregnancy or childbirth such as malaria or anaemia.

So we need to be aware that we are looking at estimates and these estimates vary from between 350,000 and 600,000 maternal deaths a year, 99% of which are believed to occur in developing countries. I think it was Disraeli who said: “Lies, damned lies and statistics!” but I would stress that no matter how uncertain we may be about the actual raw data, we should not allow ourselves to become distracted from the tragedy of maternal mortality. Not one woman should be dying in childbirth anywhere when the means are available to prevent it.

To give a slightly clearer picture of the way different countries fare (again these are in some cases estimates but when you talk in comparative terms, it can sometimes give a more accurate perception of what is going on):

In Britain[ii], the maternal mortality rate is 8.3 per 100,000 live births – and incidentally, Britain does not have the lowest maternal mortality rate by any means. Pro-life Ireland and Malta have a rather better record.

In Malawi the maternal mortality rate is 1140.1 per 100,000.

Causes

The two biggest causes of maternal death[iii] (and this is very well established) are:

- Haemorrhage
- Sepsis

Haemorrhage is the single biggest cause of maternal death anywhere in the world. It accounts for around one quarter of all cases and around a third of cases in sub-Saharan Africa[iv], followed by sepsis at around 10%. A less common but particularly horrific cause of death is obstructed labour, where the baby becomes stuck in the birth canal and the mother may be maimed for life or killed having spent days in appalling pain trying to deliver a baby who may also die in the process. This is common among very young or malnourished mothers whose pelvises are too small for them to deliver naturally.

What is particularly dangerous about haemorrhage is that there is very little time to treat it. If a woman starts bleeding during labour, she has around 12 hours, but if she has a postpartum bleed, she has more like two hours before she bleeds to death. So, if a woman is giving birth in a remote area, miles away from the nearest hospital, without easy access to affordable or suitable transport, she is highly unlikely to receive help in time, or if the hospital has just one doctor on duty or no blood bank and relatives have to be rounded up as donors, it will be very touch and go.

Beyond the clinical causes of death, there are a whole raft of reasons why women die in childbirth, all of which need to be addressed. These include, of course, lack of accessible antenatal care where certain health problems could be picked up in good time, lack of good obstetric care and trained birth attendants and facilities such as equipped operating theatres and cheap antibiotics, but also broader issues such as poor infrastructure. A study published in the Journal of Sustainable Development in Africa in 2010 found:

> Despite the recognition of the role of transport to development and the livelihoods of poor people, rural transport networks, in most developing countries, are underdeveloped and of poor quality. It is estimated that about 900 million rural dwellers in developing countries do not have reliable, all season access to main road networks and about 300 million do not have motorised access at all.

I watched an interview with an obstetrician in, I think it was Sierra Leone, earlier this year and she was saying that there is a river near her hospital but no bridge, so people will carry women in labour across that stretch of water to bring them safely to the

hospital, but if it is the rainy season, the river will be very swollen and fast-flowing and it is not possible to enter the water without being swept away. Hospital staff have watched women die, stranded on the other side of that river – in full view of the hospital – for want of a footbridge.

Then, perhaps most significantly of all, there is the poor status of women in many cultures which renders it difficult for women to access medical care in time even if it is readily available. I have come across stories of women living opposite maternity hospitals whose families would not allow them to access help until it was too late. Neglect can also be seen as a form of violence against women. As MaterCare International states:

> Violence to women may be done by ***commission***, for example, by abortion, genital mutilation, and sexual assault, especially during times of war, or by trafficking, or domestic abuse, all of which have received considerable attention by civil societies. Violence, however, may also be perpetrated by ***omission*** as in the case of neglect during pregnancy and childbirth.

If the lives of women are not valued, they will not receive the care they need. And what we must always remain acutely aware of as campaigners, when we look at figures and statistics, is that these numbers and categories alone cannot convey the full horror of young women dying unattended, in terrible fear and agony, leaving behind devastated families and other children whose own survival may well be jeopardised by the loss of a mother. In many cultures around the world, the mother is the lynchpin of the family and if she goes, the entire family is shattered. We need always to be aware of the human face of this tragedy.

Maternal Mortality as the abortion lobby's Trojan Horse

Maternal mortality has been rightly described as 'an international disgrace' but almost as grave a disgrace is the determination by pro-abortion groups to hijack the issue in order to promote abortion around the world. The abortion lobby has a long history of exploiting the suffering of women whilst claiming to act in their best interests. We are all familiar with this phenomenon as pro-life campaigners when it comes to subjects such as abortion and rape, for example. Abortion is touted as the compassionate response to rape, as though being physically invaded by a masked, anonymous male (in most cases) or given pills that cause bleeding and severe pain are cures for a brutal and traumatic act that will haunt a woman all her life. Every abortion practitioner knows that the overwhelming majority of abortions are carried out on social grounds and the abortion lobby is unapologetic about its belief that abortion should be available 'on demand and without apology', but it uses rape survivors as an emotive smokescreen to cover its unsavoury agenda and exploits their suffering for political and ideological gain.

The same is increasingly true of maternal mortality. Abortion continues to be touted as a women's health issue, from pro-abortion marches entitled "March for Women's Lives" to the emotive slogan shouted at many a pro-life demonstration: "Right to life, that's a lie! You don't care if women die!" Marie Stopes International's latest propaganda effort in the field of abortion and contraception promotion comes under the seemingly compassionate label of "Make Women Matter." But abortion has nothing to do with saving women's lives. As far back as 1992, a group of Ireland's top obstetricians and gynaecologists signed a letter in which they wrote:

> We affirm that there are no medical circumstances justifying direct abortion, that is, no circumstances in which the life of a mother may only be saved by directly terminating the life of her unborn child."

Tellingly, as I have already pointed out and can't resist mentioning again, countries such as Ireland and Malta where abortion is banned have some of the lowest maternal mortality rates in the world.

It is becoming harder and harder to justify abortion in terms of saving a mother's life, but abortion does sometimes kill women and it is the "unsafe abortion" argument that is being used most aggressively to promote abortion around the world. Our own Department for International Development (DFID) uses unsafe abortion as its major line of defence in promoting and funding abortion, claiming that unsafe abortion is a significant cause of maternal death. International organisations including the World Health Organisation list 'unsafe abortion' as one of the major causes of maternal death after haemorrhage and sepsis, but the category is misleading for a number of reasons.

Firstly, this category may include deaths as a result of spontaneous abortion, otherwise known as miscarriage, giving a distorted picture of the number of women who are dying as a result of *induced abortion.* Secondly, it should be noted that it can be extremely difficult even for a trained doctor to determine whether a woman in the first trimester of pregnancy is experiencing life-threatening complications as a result of miscarriage or abortion. The symptoms are so similar that an online abortion group which sell pills to women in pro-life countries, tells women who suffer complications:

> If you live in a place where abortion is a crime and you don't have a doctor you trust, you can still access medical care. You do not have to tell the medical staff that you tried to induce an abortion; you can tell them that you had a spontaneous miscarriage…The symptoms are exactly the same and the doctor will not be able to see or test for any evidence of an abortion.

Thirdly, we should note the loaded use of "unsafe" here. Any medical procedure which involves the ending of one or both human lives involved is by definition unsafe and it is unsafe whether it occurs in Nairobi or New York. The abortion lobby has been very successful in creating a false association between 'safe' and 'legal' abortion (a favourite line of pro-abortion politicians is that abortion should be 'safe, legal and rare') with the implication being that if abortion were only decriminalised in every country of the world, maternal deaths as a result of abortion would be virtually eliminated. However, any medical procedure involves a level of risk, and abortion, legal or otherwise, is no different. 8.2% of maternal deaths in developed countries[v] (where abortion is most likely to be legal) are the result of abortion complications; in India where abortion is legal, the mortality rate from abortion counts for around 16% of all maternal deaths. South Africa, which has had abortion on demand for years, has witnessed a fourfold increase in maternal mortality since a UK-funded abortion organisation set up clinics around that country. As SPUC's Peter Smith commented:

> It is farcical for the government to talk about safe abortions in situations without sterile surgical facilities, safe blood transfusion or emergency back-up. Running abortion clinics in slums, shanty towns and the bush will harm or kill women as well as killing babies.[vi]

Women in Britain and women in South Africa have access to legal abortion, but in the end, a woman experiencing abortion complications in Britain can get emergency help within minutes, while a woman living in an isolated settlement in South Africa can't. If the abortion lobby is going to highlight the risks to women of unsafe abortion, the logical response would surely be to campaign against a medically unnecessary procedure and to work instead to offer women the assistance they need when facing a difficult pregnancy.

But the promotion of abortion can be a killer of women in a much more subtle and indirect way. Donna Harrison, president of the American Association of Pro-Life Obstetricians and Gynaecologists has written:

> In addition to the direct effects of induced abortion on women, there is the dangerous diversion of financial resources from interventions known to reduce maternal mortality: skilled birth attendants, antibiotics, blood banking, and uterotonics.

> Abortion, spontaneous and induced, accounts for less than 5 percent of maternal mortality. It is scientifically, medically, and morally unacceptable to divert resources from interventions proven to reduce maternal mortality to the provision of abortion, under the guise of "decreasing unsafe abortion." The better way to reduce the human rights dimension of maternal mortality is to provide resources targeting the causes of 90 percent of maternal mortality."

I have always found it rather illogical that secularists accuse religious people of being fundamentalists blinded by doctrine or dogma – whatever word they think sounds more sinister – when it is perfectly possible to be blinded by a secular ideology. There can surely be no greater political fundamentalism than that which puts an ideology before the safety of the very women it claims to want to protect.

In their paper *Safe Passages: Pro-Life Response to the Tragedy of Maternal Deaths*, George Mulcaire-Jones, M.D., and Robert Scanlon, M.D. expose the hypocrisy of the abortion lobby with devastating eloquence:

> There remains a chasm between the villages of Africa and the cities of Geneva, Stockholm, London, and Washington, D.C. It is the chasm representing the distance between a woman dying in a birthing hut without sanitation, running water, or hope, and the carpeted board rooms where strategies are developed and priorities assigned. Vast resources, which should have been directed to funding improvements in essential obstetrical care, have gone to a different agenda—so called "reproductive health." Rather than focus on the real causes and solutions to maternal mortality, Safe Motherhood has become entangled within a "reproductive rights" agenda, which emphasizes access to contraception and promotes abortion.
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> In the middle of the night, a woman bleeding to death from a postpartum haemorrhage cannot be saved by a contraceptive device or a reproductive health mandate. An asphyxiated newborn cannot be resuscitated by the failed intent to prevent his or her conception.

The western obsession with promoting its own vision of sexuality onto the rest of the world is not only costing the lives of the unborn; it is costing the lives of women through neglect.

The most desperate pro-abortion argument - 'they will do it anyway' - is illogical and insulting to women, but again, a very common argument in any debate on sexuality. But if it did not involve a western ideology about human sexuality, would we really be so defeatist? So cowardly? Some 10% of 15 and 16-year-olds in this country self-harm, but it would be the height of heartless irresponsibility to respond by teaching them how to cut themselves as safely as possible. You don't hear the Government say: "oh well, it's a pity depressed teenagers self-harm but we don't want to interfere with their choices and it's a losing battle. They'll find a way." The answer is prevention. The difference here is that abortion is not regarded as a problem; it is regarded as an opportunity.

Childbirth is rendered safe by a range of entirely ethical solutions. No one has a problem with making available to women such life-saving interventions as: antenatal monitoring, trained midwives, caesarean section, blood transfusion (and with it the ability to store blood safely), good sanitation and antibiotics. There is no reason why there should be this massive ideological battle going on over the bodies of dead women and babies.

Population

I would like to speak very briefly about population. This is a huge subject and really deserves a talk all on its own, but population control is so readily bandied about as a solution to Africa's problems that it merits a mention here. The received wisdom is that poor people, particularly Africans, just can't stop breeding

and that people = poverty. A few facts for you to mull over:

- The population density of Europe is 134 people per square mile.
- The population density of Britain is 634 people per square mile.
- The population density of Africa is 66 people per square mile.

And yet we reserve the right to dictate to African women how many children they should have. Western governments spend millions providing contraception to developing countries when one in eight people around the world, the overwhelming majority in developing countries, have no access to safe drinking water.[vii]

It is said that one American consumes the same resources as 12 Bangladeshis. So if anything, rather than westerners having the arrogance to tell people in developing countries to stop breeding, they have every right to tell us to stop being so greedy. You don't have to have a new mobile phone every six months; you don't have to run a Land Rover to cart your two children across London to their smart prep school; you don't have fly out to the other side of the planet every year to enjoy a nice holiday. There is nothing wrong with considering on a daily basis the impact your activities are having on the planet. I am not an environmentalist but I do believe that we are the stewards of creation and the planet does not owe us a consumerist lifestyle.

A few words of warning regarding the population debate:

Unmet Need for Contraception

You will hear the expression "unmet need for contraception" quite a bit in debates about population and development – but what exactly is an unmet need for contraception and how is it defined, let alone calculated? One definition on a UN website[viii] is:

> The percent with an unmet need for family planning is the number of women with unmet need for family planning expressed as a percentage of women of reproductive age who are married or in a union. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.

For a start, as with other politically-motivated estimates, how accurate can this estimate be? Has UNFPA conducted extensive surveys, sending armies of smiling individuals with tabards and clipboards into every remote region on the globe to ask women whether or not they fancy popping the Pill? Even if surveys were a reliable way of gaining objective data, which they notoriously are not, it is highly unlikely that more than a tiny percentage of women in developing countries have ever been consulted on the matter.

Pro-contraception agencies tend to make vague claims that "women we talk to want contraception" whereas, strangely enough, groups like the Population Research Institute have found that women in developing countries *they* consult do not even include contraception on their wish-list. They're too busy requesting safe drinking water, vaccination programmes and basic education for their children.

But even the definition is pretty shaky. Some pro-abortion agencies have pointed out that, for starters, it is a bit odd to include only women who are married or in a union when, just occasionally, unmarried women also get pregnant. Most obviously though, the definition may well completely exclude couples who are using natural methods of family planning. Under this definition, I would have an unmet need for contraception. My doctor certainly thinks so – I don't. Unmet need or an assumption of a need?

Family Size

Beware western assumptions about family size. If you live in a country with little or nothing in the way of a welfare state and high infant mortality, large families do not equal poverty. Children = security. Children = the future. In a recent article[ix], a Nigerian

engineer wrote – and I'm paraphrasing slightly because it was quite a lengthy article:

> Western media are shrilly calling for Nigeria to put a check on her population growth. No way, sorry. We Nigerians are rejoicing. Africans love children. First for financial security. ..Second, many children ensure that we avoid the problem of ageing populations. We know that in Europe and America, birthrates are far below replacement level. Their populations are ageing and a huge pension debt is resting on the shoulders of shrinking numbers of their working youths. A day of reckoning is looming for them. Nigerians want to avoid this. Third, our large population supplies our economy with the dynamic and youthful workforce it needs to grow, as well as huge markets for all types of businesses. The real reason for poverty is corrupt rulers, not a lack of birth control.

Last Resorts

Beware most of all promises by environmental groups that they are in favour of voluntary one or two child policies only and forced one or two child policies as 'a last resort'. That is the position of groups like Population Matters[x]. When the state gets involved in dictating family size, it is difficult to see how such a policy will not be coercive on some level. Even making having a third child socially unacceptable involves a level of coercion because most people don't want to be socially excluded or stigmatised. But a state two-child policy would necessarily involve making it easier to have a small family but more socially and economically difficult to raise a larger family. That's rather the point. I would say, incidentally, as someone attempting to raise three children in the south-east of England, that we are pretty close to that situation already. As to forced policies being a 'last resort', I am very suspicious of the words 'last resort.' I generally find people talk about the 'last resort' as a way of justifying a course of action they know instinctively to be unjustifiable. It is actually quite a threatening position to take, carrying with it the implication that the people touting the last resort are moderate, forbearing individuals who would "hate to see it have to come to this" and those who will suffer the last resort have in some way brought it upon themselves. I have heard all sorts of disgraceful things justified as a last resort – bullying, malicious gossip, deceit, and even such human rights abuses as torture, and here the population controllers are saying 'get yourself sterilised freely or the state may one day have to force you.' If an action is objectively evil and destructive, a gross attack on human rights, then surely it can never be justified even a 'last' resort?

A Pro-Life Response

It is not enough simply to condemn the actions of anti-life forces for exploiting the suffering of women to promote the ideology of abortion. The tragedy of maternal mortality needs to be faced and it requires a courageous and honest response. Abortion is not the sad necessity, nor the empowering procedure presented by groups like Marie Stopes International and the International Planned Parenthood Federation: it needs to be recognised as part of the problem. As Robert Walley has stated:

> Unfortunately, the international safe motherhood initiative has accepted the current culture of death prevalent in obstetrics and gynaecology, as abortion is included as the solution to maternal health problems. All of this points to a real poverty - the lack of love and compassion.

The staff and volunteers at MaterCare International know something about love and compassion for the forgotten mothers of the developing world. They provide life-saving assistance to women and babies in Kenya and Ghana and are providing emergency help in Haiti since an earthquake devastated that country. They are forced to work without state funding and are entirely reliant upon donations from members of the public. MCI's mission statement links their work directly with the papal Encyclical *Evangelium Vitae*: they are

"improving the lives and health of mothers and babies both born and unborn, through new initiatives of service, training, research, and advocacy designed to reduce the tragic levels of abortion world-wide and maternal and perinatal mortality, morbidity in developing countries."

As pro-life campaigners, we know that maternal mortality is a tragedy and that abortion is not the answer, but I believe that we are under an obligation to turn that knowledge into action. There is a very real need for a campaign to lobby for good maternity care for women in developing countries, to dispel the myths about abortion being put about by interested parties and to sound the alarm about the promotion of abortion by stealth in the name of maternal health. In doing this, we can reach out to those who support our principles but have never considered becoming involved in our work. There is a terrible tendency, particularly on the parish level, to regard pro-life and social justice campaigning as entirely separate and in some ways, diametrically opposed. But pro-life campaigning should be regarded as just as much a part of social justice as campaigns to provide vaccination programmes for infants in sub-Saharan Africa. It is the terrible blind spot in current human rights campaigning – the failure to acknowledge the rights of every member of the human family – and we need to be there, linking up with like-minded people who are pro-life but maybe have not seen this as the priority until now, to show that the pro-life movement is the ultimate human rights movement which excludes no member of the human family under any circumstances.

And through such a campaign we can offer hope to mothers around the world who face the prospect of giving birth in fear and trembling rather than with joy. Whenever anyone tells me that a situation in a foreign country is none of their business (and I hear that comment disturbingly often) I ask how they would feel if their own sister were facing death for want of medical care that they themselves take for granted. This is not just an attempt to make people feel guilty. Radical feminists talk about the universal sisterhood, though they are sadly prepared to show a remarkably callous attitude to women who fail to meet the entry requirements. We must speak of sisterhood and show the world we mean it.

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i http://www.hindawi.com/journals/jp/aip/958262.pdf
ii http://www.guardian.co.uk/news/datablog/2010/apr/ 12/maternal-mortality-rates-millennium-development-goals
iii http://www.maternityworldwide.org/pages/causes-of-maternal-mortality.html
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vi http://www.spuc.org.uk/news/releases/2011/january04
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