1 WHY DID MRS X DIE?

SESSION 1
WHY DID MRS X DIE?

Aims

- To enable students to reflect on the factors that make maternal death more likely.
- To consider how these factors can be removed or reduced in their own locality through effective community-based health care.

Objectives

On completion of Session 1, students will be able to:

- Identify the predisposing factors to maternal death.
- Discuss the importance of community-based care in relation to safe motherhood.

Plan

Video “Why Did Mrs X Die?”, or by story telling (30 minutes).

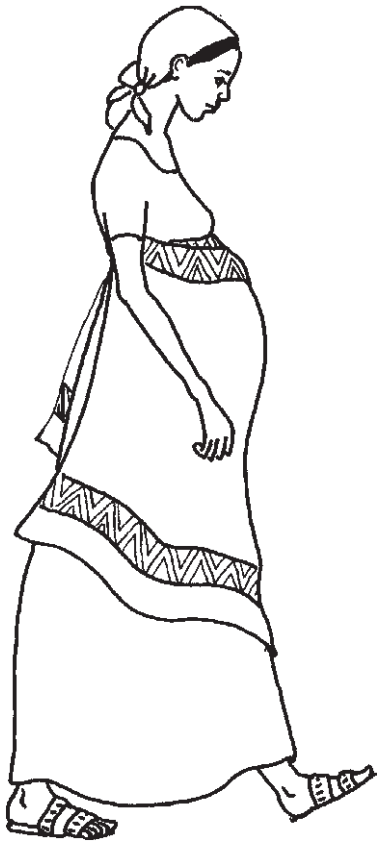
Resources

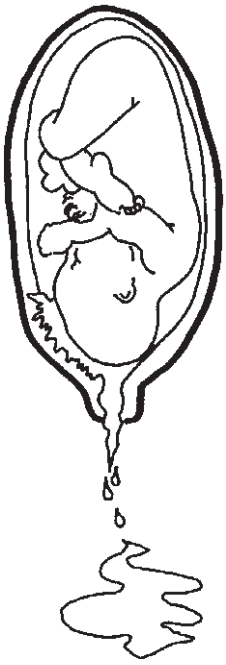
In Session 1, the story of Mrs X is adapted from the video “Why Did Mrs X Die?”.
This video is on sale from the World Health Organization, Marketing and Dissemination, CH-1211, Geneva 27, Switzerland. email: publications@who.int

INTRODUCTION

Start the session by telling the story "Why did Mrs X die?".

TELLING THE STORY: WHY DID MRS X DIE?

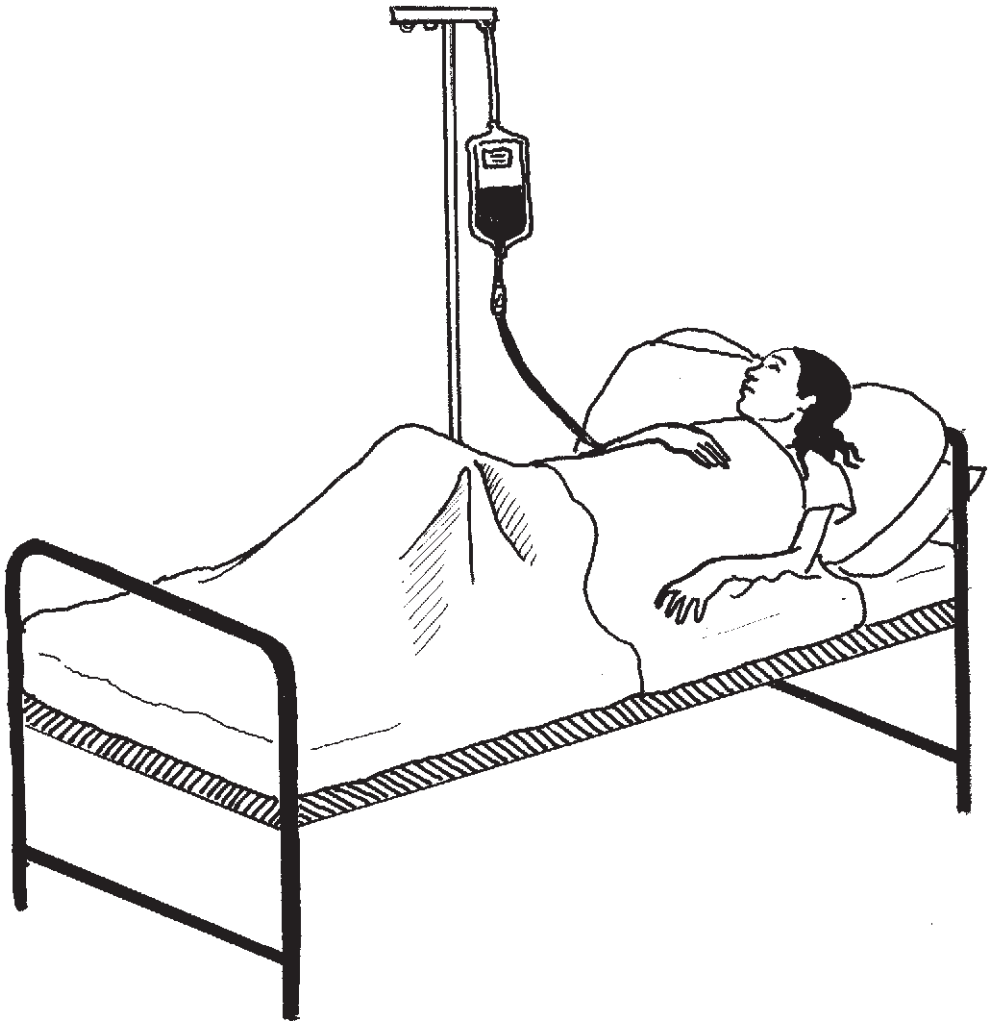


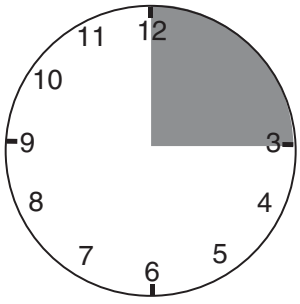


This is the story of one case of maternal death. For the sake of anonymity, let us call our unfortunate woman, Mrs X.

Mrs X died during labour in a small district hospital. The physician in charge had no doubt why Mrs X died. It was a straight forward clinical diagnosis - a case of antepartum haemorrhage due to placenta praevia, which means that the placenta, or what we call the "afterbirth", was situated too low down in the uterus. A woman with this condition will inevitably develop bleeding in the latter part of pregnancy or before delivery. The physician was satisfied with the diagnosis, looked up the book of International Classification of Diseases, entered the right code number for the condition and closed the file on Mrs X.

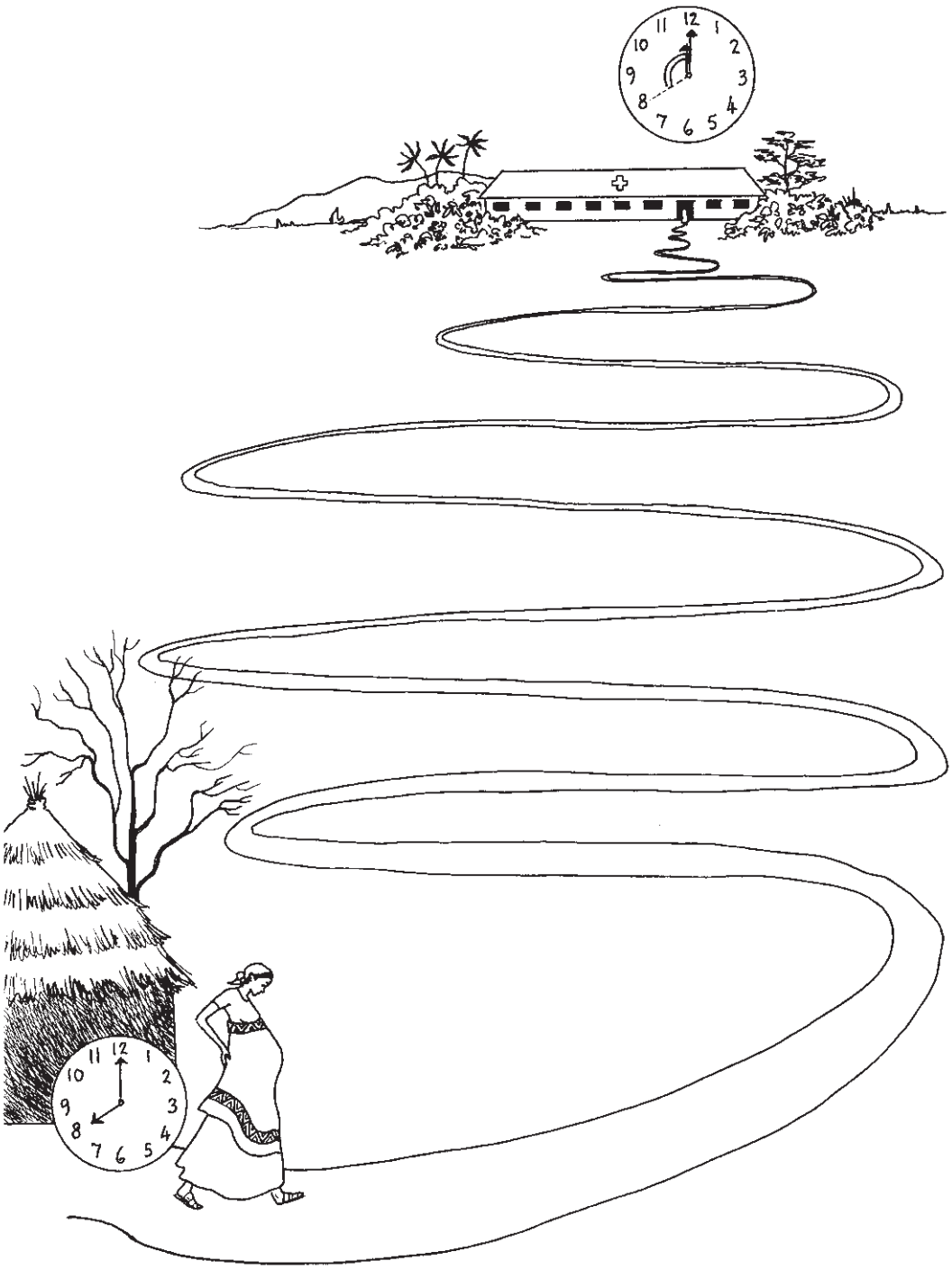
But the question is not completely answered, and there are others who are still looking for other answers. The obstetric profession has a small committee which is making confidential inquiries into the causes of maternal deaths according to standards that have been developed by the International Federation of Gynaecology and Obstetrics. The committee met, asked for the complete hospital record of Mrs X and examined the record in more detail. The file on Mrs X was re-opened.





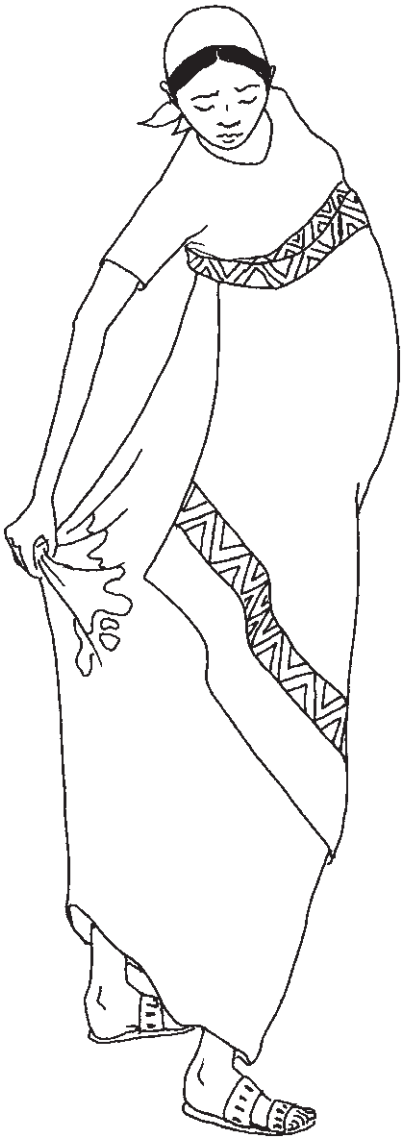
On reading the file of Mrs X, the committee found out that there were two striking points in her hospital record. The first point was that although she was admitted to hospital as a case of severe bleeding and in a condition of shock, she received only 500 cc or ½ litre of blood by transfusion. That was all the blood the hospital had available to give her and that amount was barely sufficient to compensate for her severe blood loss. The second point was that Mrs X had to undergo caesarean section in the hospital to stop the bleeding. That operation was carried out three hours after her admission. Mrs X died during the operation.

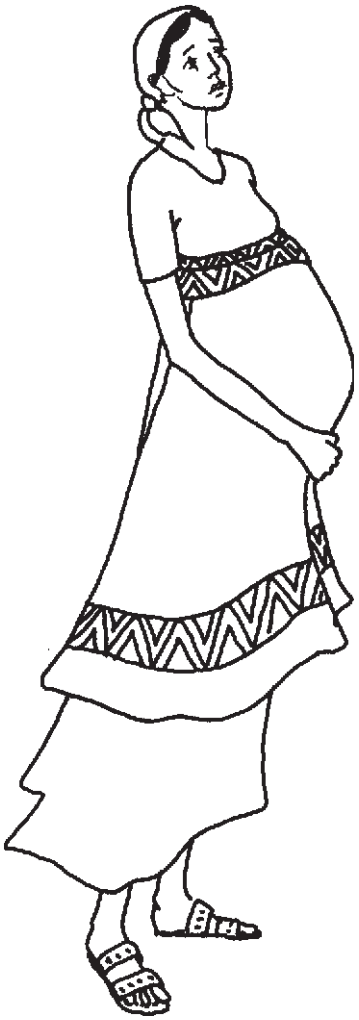
The committee looked into the case which said that the death of Mrs X was avoidable. The committee argued in its report that, if blood transfusion had been more readily available, and if the service had been better prepared to deal with emergencies, a life would have been saved.



It took Mrs X four hours to reach hospital from the time she started bleeding severely, because transport was not readily available to take her to the hospital.

It was also revealed that this was not the first time she suffered bleeding. In fact she had two minor episodes of bleeding during the same month and on both occasions the bleeding stopped spontaneously. This is a very dangerous signal in late pregnancy. It always indicates that a severe attack of bleeding is imminent, yet Mrs X was never warned about this and no action was taken.

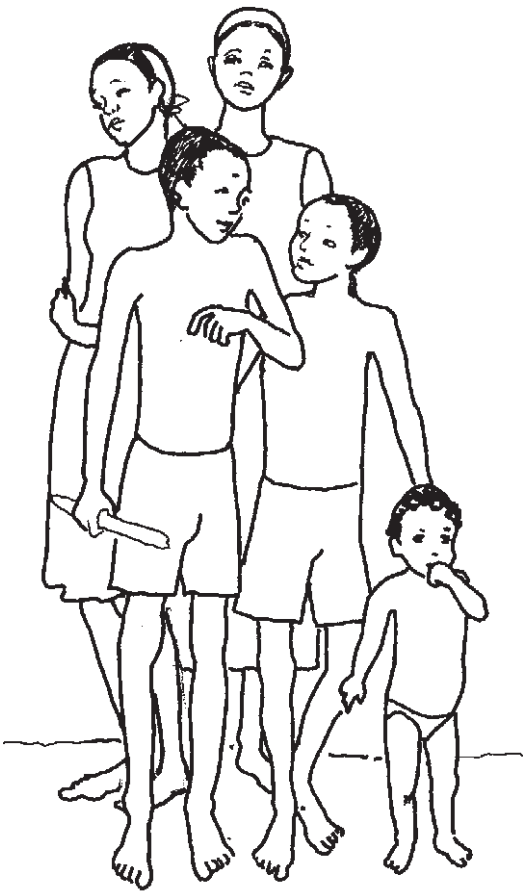




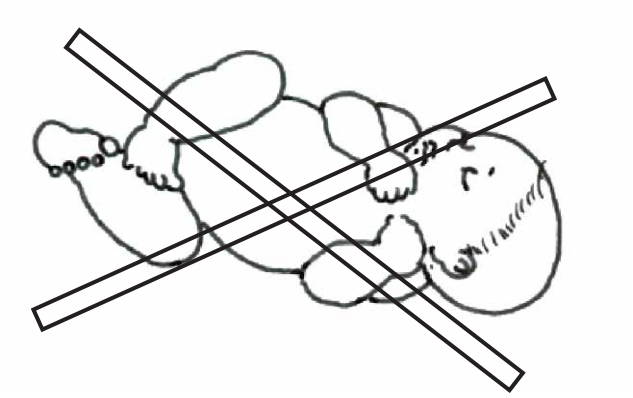
Mrs X was not a very healthy woman. Even before pregnancy, she suffered from chronic iron deficiency anaemia caused by malnutrition and parasitic infestations. That severe anaemia must have contributed to the fact that she could not endure the additional severe blood loss. Her reserves of blood were already at a very low level.

Mrs X did not have access to any sort of prenatal care during her pregnancy.

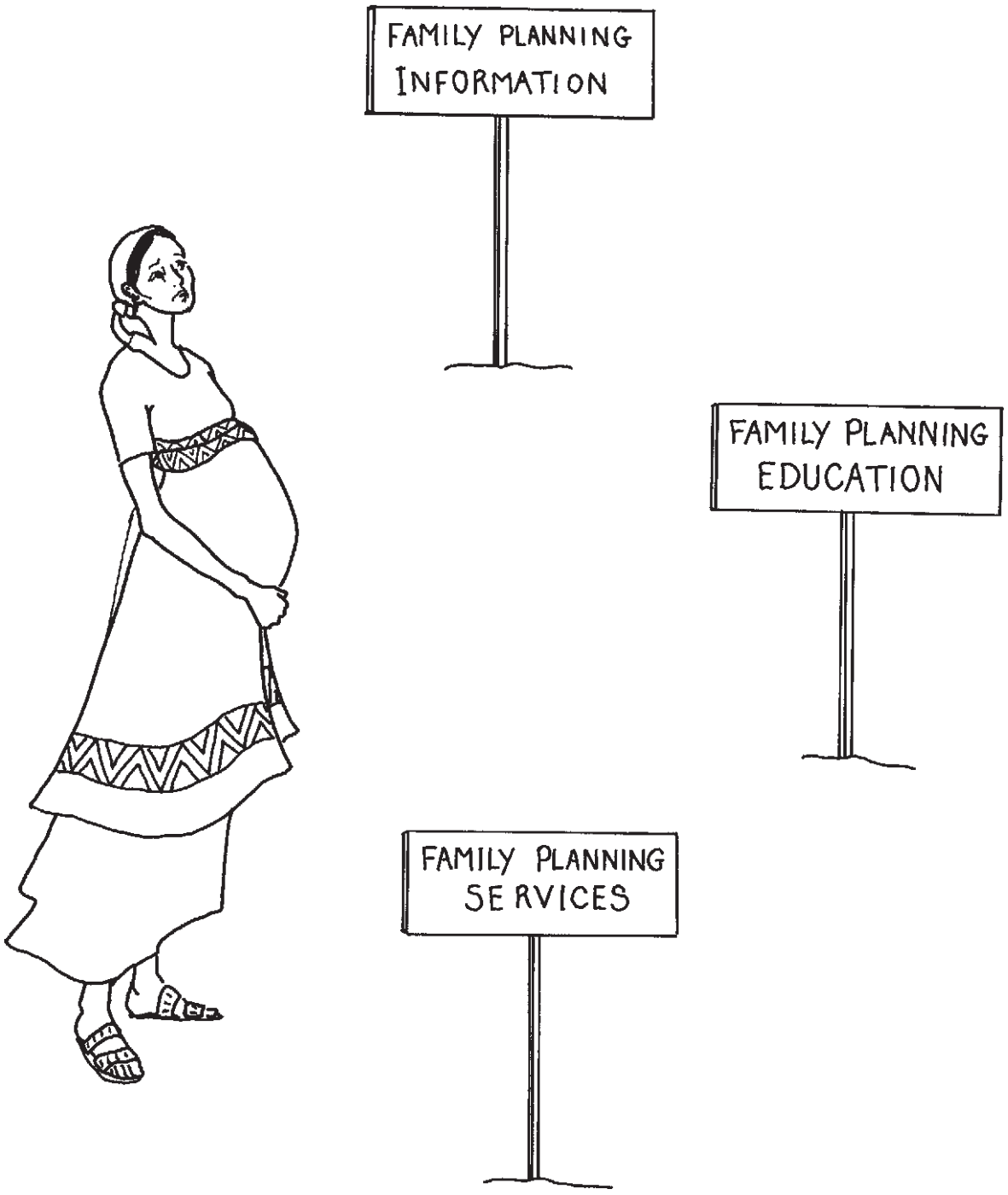
Mrs X is 39 years old, five of her children are still living, three of them are males, and Mrs X did not want another child.



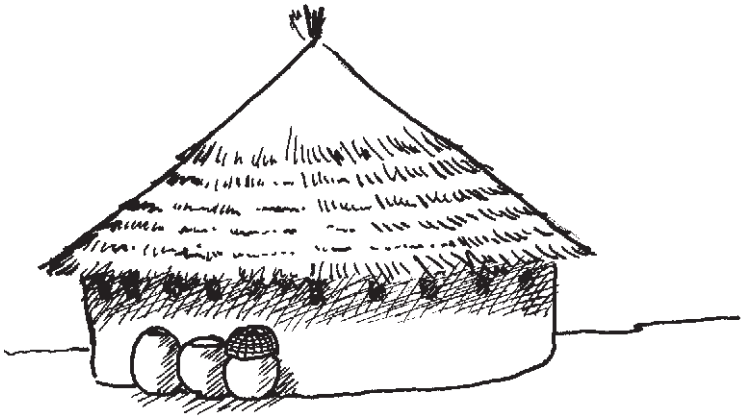
In addition, because of her age and because of her parity, her pregnancy carried a much higher risk than her previous pregnancies.



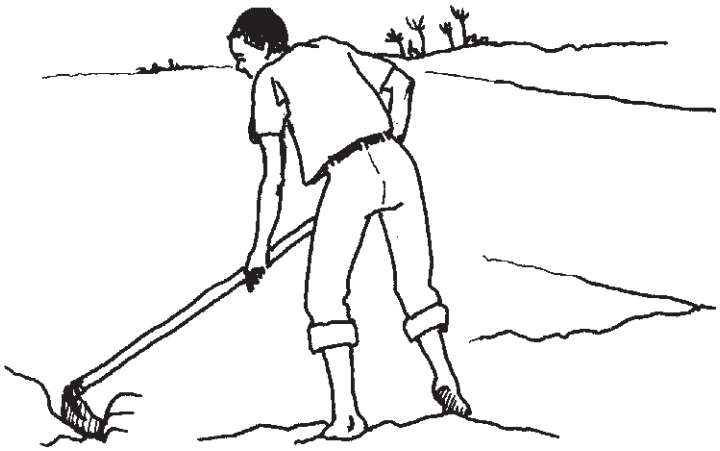
Mrs X never had access to any family planning information, education or services, and therefore never had the opportunity to use any method of family planning in her life.

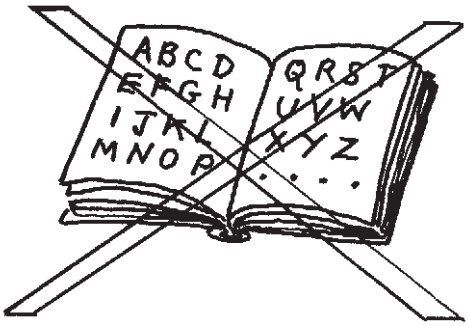


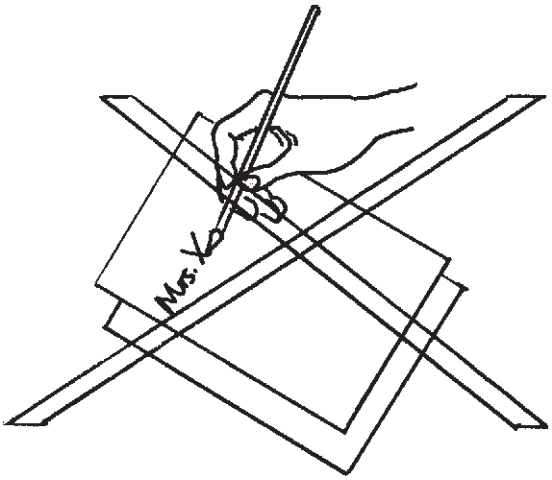
If this unwanted pregnancy of Mrs X had not taken place, she would not have died from the cause she died from.

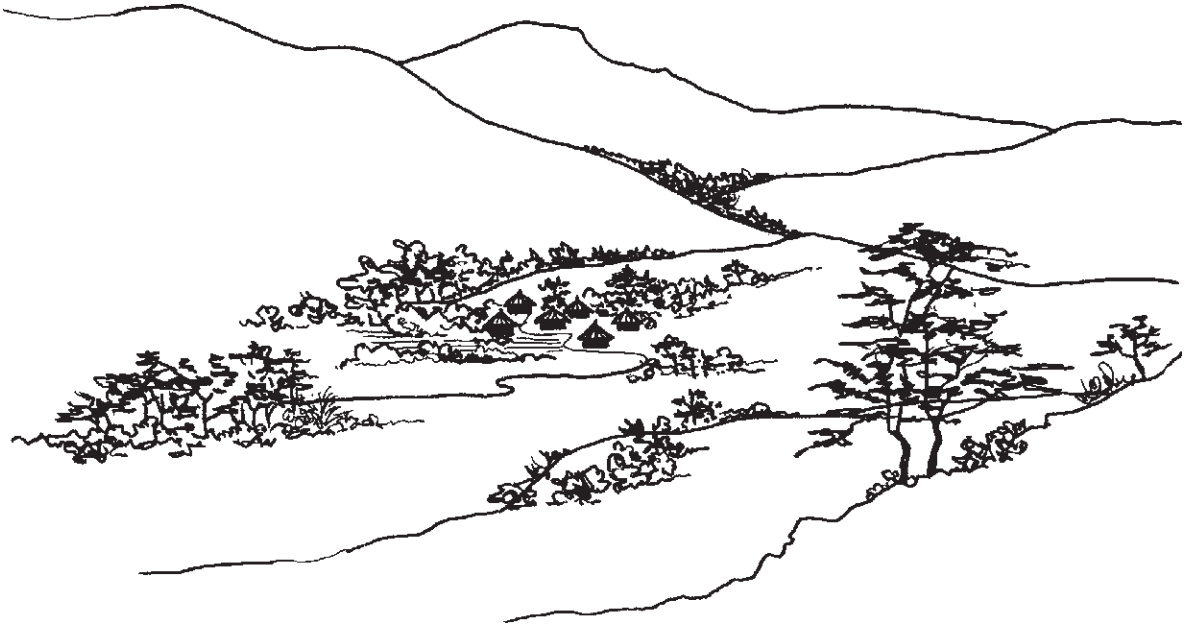


Mrs X was also a housewife, and her husband a poor agricultural labourer.

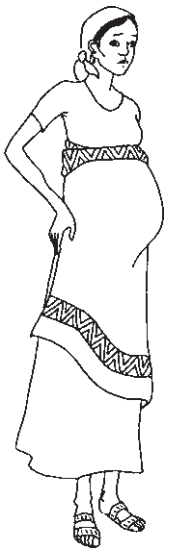








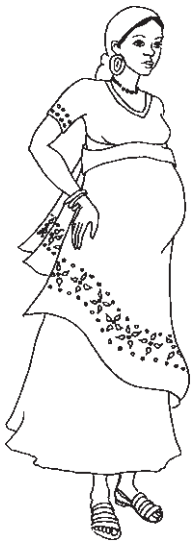
She was an illiterate woman and she lived with her husband in a remote village.



A woman of Mrs X's socioeconomic position has a relative risk of maternal mortality:

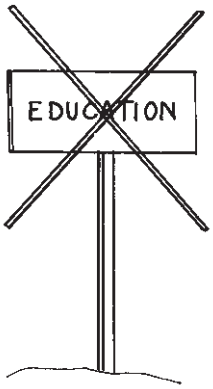
5 times more than the average in the whole country.

10 times more than a woman in a higher socioeconomic position in the country in which she is living.

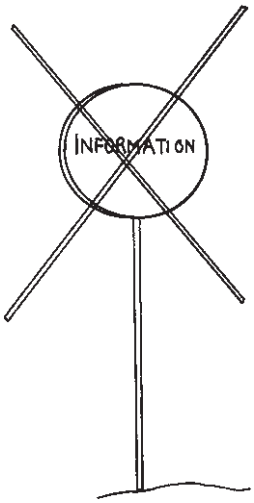


100 times more than a woman living in a developed country.

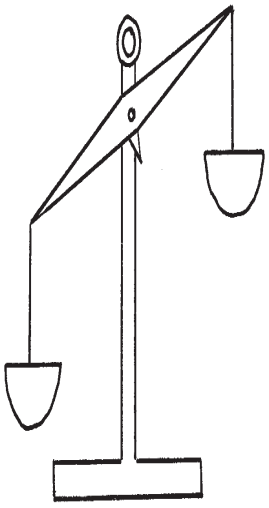
The real reason why Mrs X died was because of her socioeconomic position:



Mrs X died because of poverty

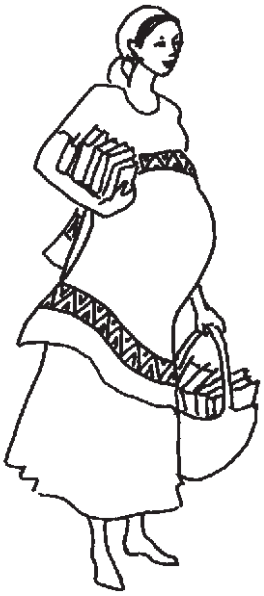


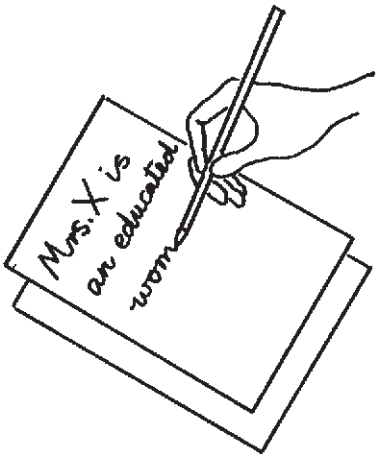
Mrs X died because of lack of knowledge and information

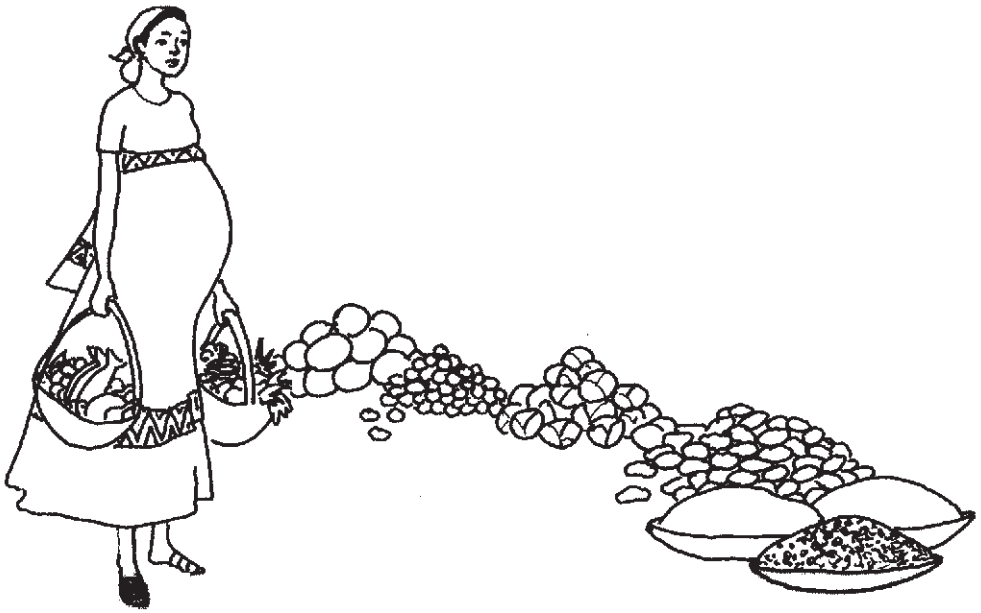


Mrs X died of social injustice

If Mrs X had been an educated woman, if she had been gainfully employed, and if she had had her fair share of nutrition within society, her risk of dying would have been much less.

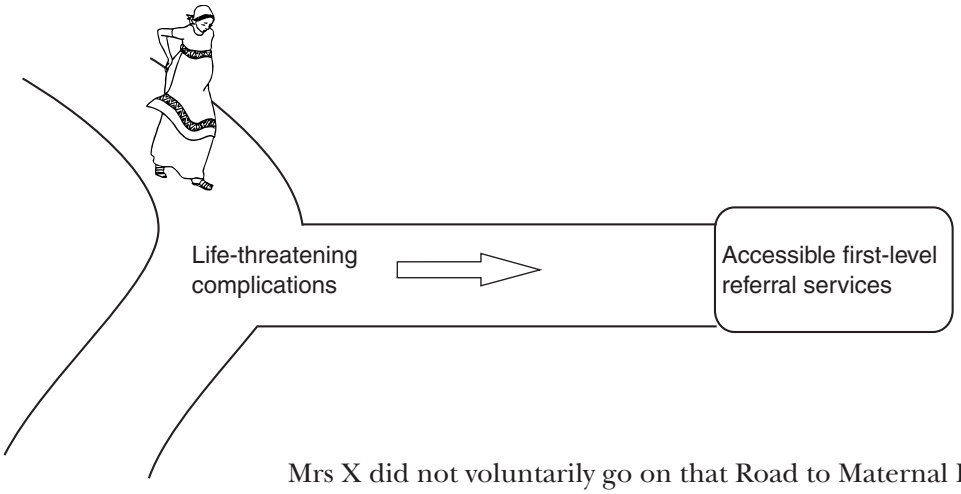






It is clear that there are different perspectives in the way one looks at the causes of maternal mortality. In order to answer the question "Why did Mrs X or other Mrs Xs die?" we need to take all these perspectives into consideration. In other words, we need to reconstruct the story of Mrs X.

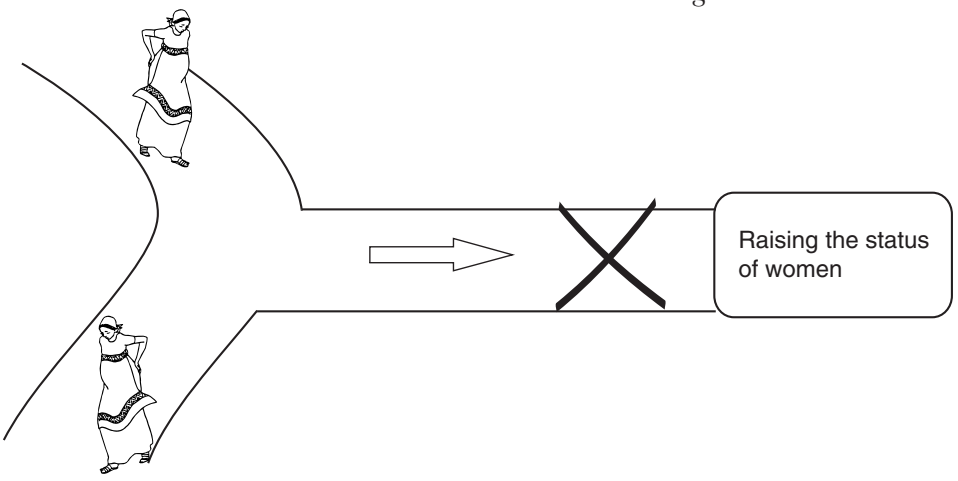
We need to retrace the steps of Mrs X along what one can describe as The Road to Maternal Death.



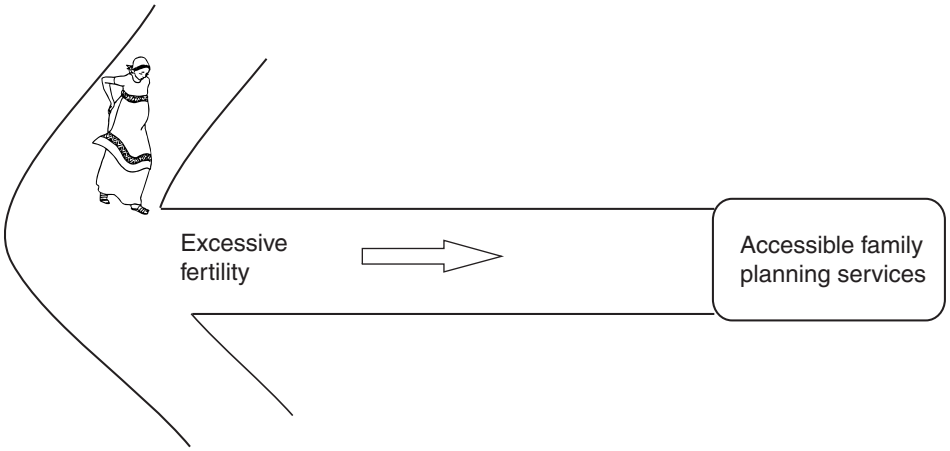
Mrs X did not voluntarily go on that Road to Maternal Death. She was led to the start of the Road by the poor socioeconomic development of the community in which she was born, and in which she lived. But it is not just the general level of socioeconomic development that matters. Even more important is the equity with which the benefits of socioeconomic development are made available to members of the community. As a female, Mrs X did not get an equal share of whatever little benefits of socioeconomic development were available in her community.

At that stage on The Road to Maternal Death there was a way out for Mrs X.

- If Mrs X had had the opportunity for some education, for gainful employment, or for proper nutrition she would probably have found her way off The Road to Maternal Death. Unfortunately, that exit was not available to Mrs X and she had to continue along the Road.



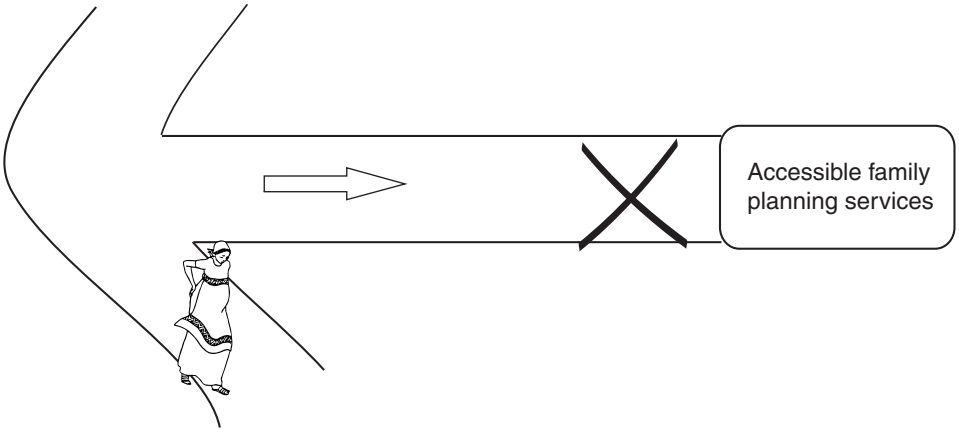
The next stretch of the Road for Mrs X was excessive fertility.



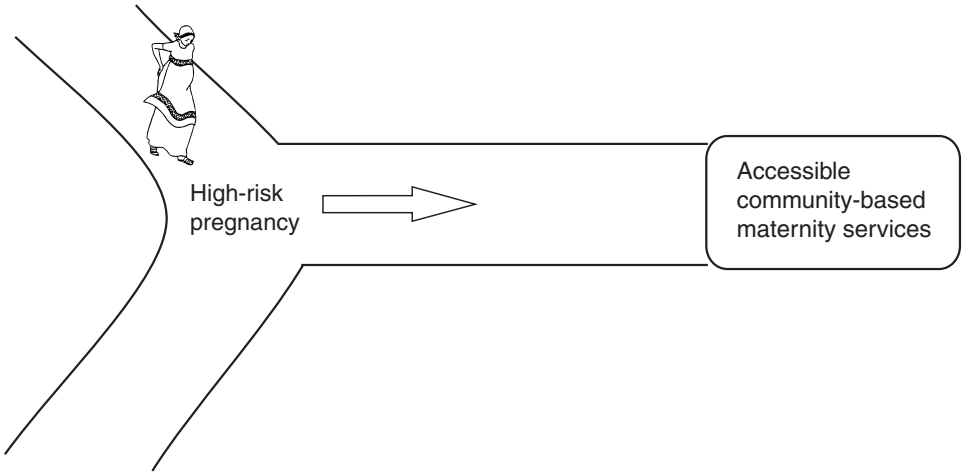
Her fertility, and childbearing, was her only acknowledged contribution to the society in which she lived. Children were the only goods she could produce and the only goods she could deliver. Her status as a woman in her community depended completely on her role as a mother. Excessive fertility not only increased her chances of travelling further along The Road to Maternal Death, but because of advancing age and parity she was at increasingly higher risk during pregnancy and childbirth.

Still at this stage on The Road to Maternal Death there was a way out.

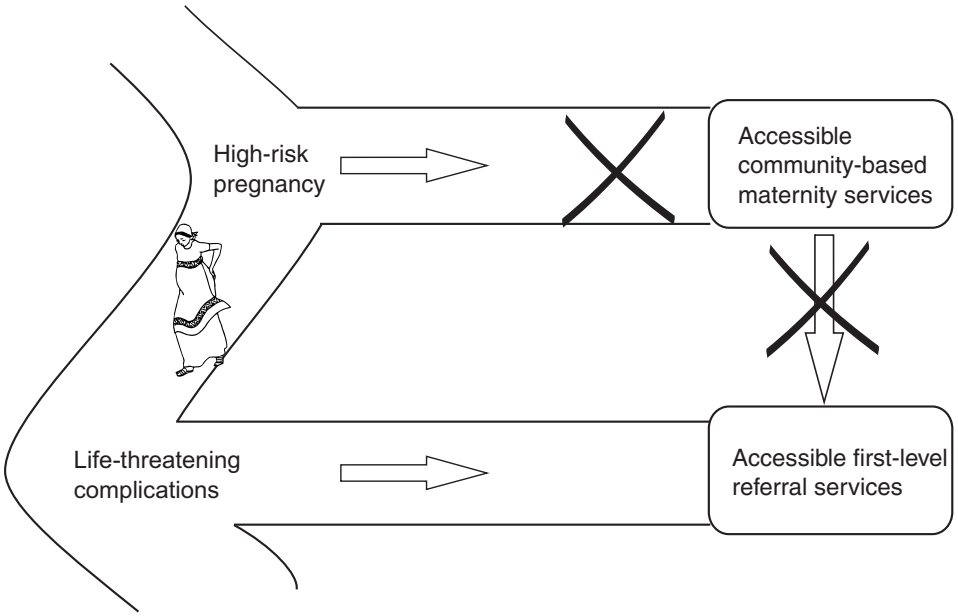
- If Mrs X had access to family planning information, education and services, she could have found her way off the dangerous Road. Mrs X was denied that exit and had to continue her march along the Road



Now, because of her advanced age, because of her advanced parity, because of her poor nutrition, because of her severe anaemia, she came under what we call an obstetric category - the category of high risk pregnancy. By high risk pregnancy we mean that small group of women who have most of the complications. That was the stage Mrs X found herself at, yet even at that stage there was still a way out.



If community-based maternity services had been available; her high risk category would have been detected by simple screening; her anaemia would have been corrected; warning signals such as her episodes of bleeding would have been carefully noted; and she would have been referred to the nearest hospital service in time while she was still in a good condition. That exit was not open to Mrs X and she had to continue along the Road.

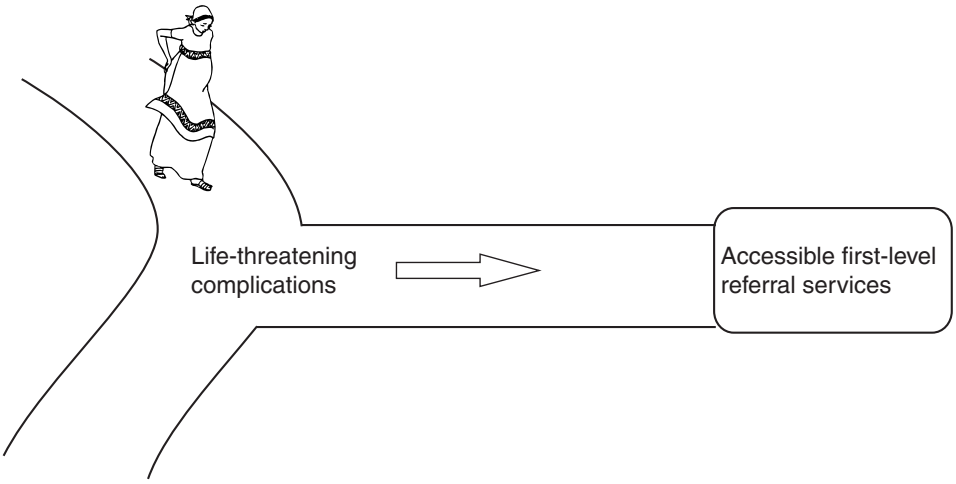


And that was the critical part of the Road, that was the stage of what we call life-threatening complications. These include conditions such as haemorrhage, eclampsia, sepsis, obstructed labour, complicated abortion and other less common but serious conditions.

The inevitable happened. Mrs X developed her life-threatening complication, her antepartum haemorrhage.

Even at this stage there was a last way out.

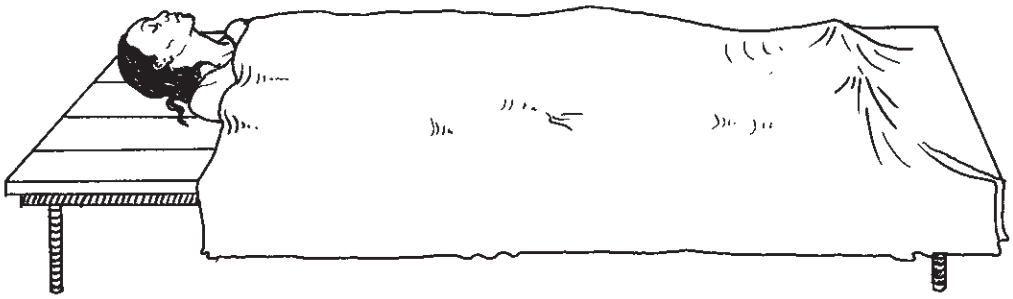
If she had access in time to good services at first referral level so that her serious life-threatening condition could have been properly managed, Mrs X could have been saved. But that was her last chance and Mrs X lost that last chance.



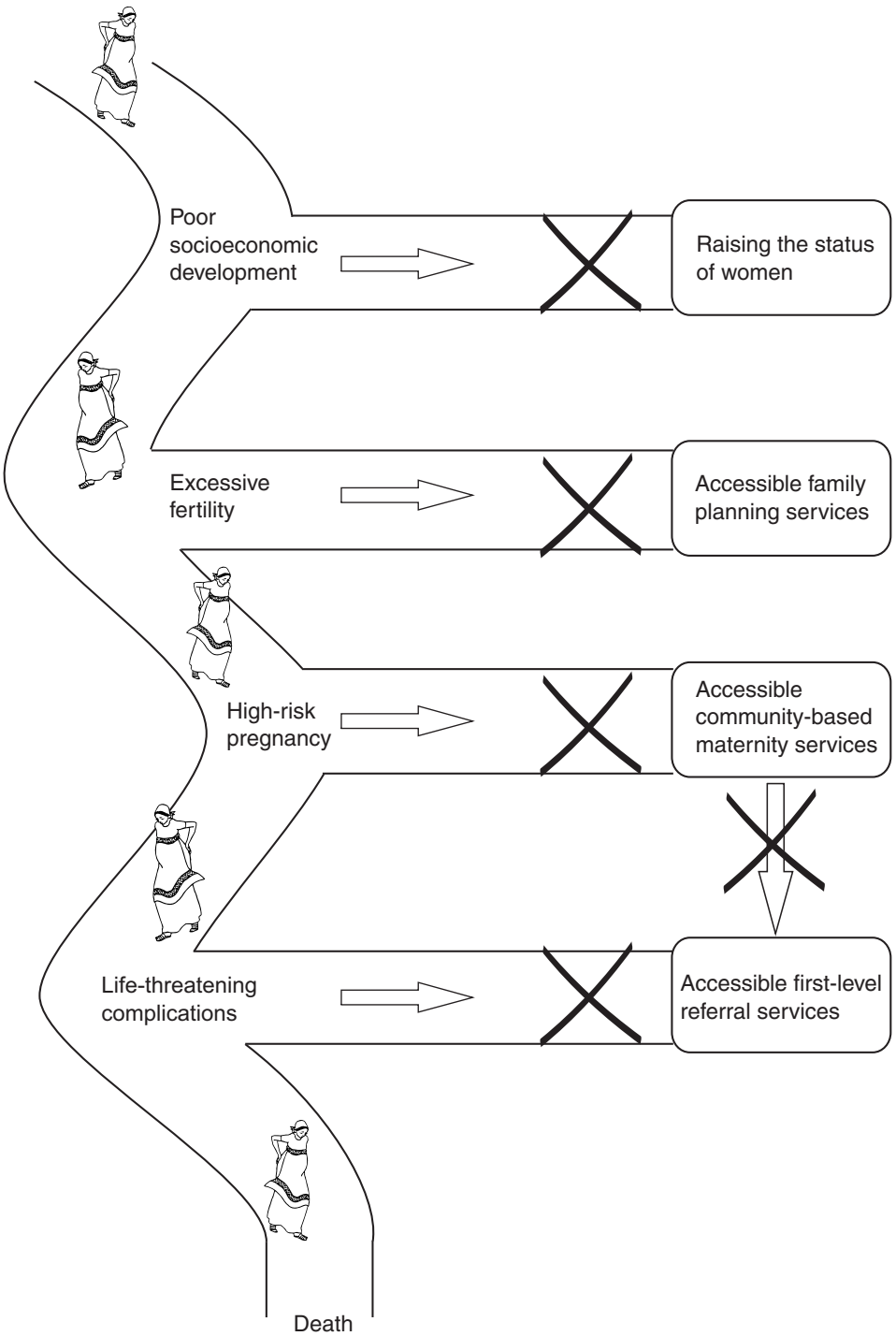
That was the unfortunate journey of Mrs X along the slippery, dangerous Road to Maternal Death. The journey has left us with a vision of how women die and how women can be rescued. Women risk death when they step onto The Road to Maternal Death at any stage. Women can be rescued if they can be helped to follow one of the ways off the Road. It may not be possible to restrict completely the access to The Road to Maternal Death. It is certainly possible to let women off the Road through its various exits, but any successful strategy for mothers' survival will have to effectively utilize every exit along The Road to Maternal Death.

If we try to emphasize only the earlier exits then we are going to miss the women who join the Road later on or who continue along it. If we emphasize only the later exits, the medical exits, and we do not give equal emphasis to the earlier social exits, the load on those medical exits will be too much for the medical services to cope with.

Mrs X is dead.



There are millions of Mrs Xs still travelling along The Road to Maternal Death.



In the 30 minutes it has taken to tell this story, another 30 women (one for each minute) will have reached the dark end of the Road. These mothers need to be saved, they can be and they must be saved.

It is often effective to take a break after this. Students can reflect on what they have seen and heard.

The next session will take the students out into the community to make discoveries for themselves. Make sure that arrangements are clear and visits are well organized.