Tsunami and the silent tide: the invisible challenge of women's health

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The wall of water rolled in and retreated, taking with it loved ones, homes and livelihoods. The cries of loss and pain in Indonesia, Thailand, Sri Lanka and southern India are now followed by the huge task of resettling, building shelter, searching for potable water, finding food and, at the same time, trying to be productive under staggering grief. In most cases the everyday problems around being poor are now compounded by the loss of work and uncertainty about where to resettle.

Women suffered differentially in the tsunami disaster. While the total death toll will never be known accurately, it is known that more women and children died than men. Perhaps the men were better swimmers; perhaps children were more likely to be on the beach. But among the survivors it is the special needs of women that are being overlooked.

Many relief agencies work hard to respond to large-scale tragedies, whether caused by nature or human conflict. In the past decade there has been some recognition of the needs of women in dire emergencies but, by and large, responses remain constrained and unrealistic. In its procedures book for emergency situations, Médecins Sans Frontières mentions that family planning can be offered but only under tightly restricted situations such as if the refugees are expected to stay in the camp for at least another 6 months, and only after the need for contraception has been thoroughly assessed. The instructions also say that the acceptability of such a programme to other organisations working in the camp, especially any local groups of the host country, must be considered.[1] But in the real world men don't stop seeking sex because of an earthquake or tidal wave. Contraceptives and, perhaps, emergency contraception should be an essential part of any disaster response as are clean water and antibiotics.

In the case of the tsunami it is estimated that 150 000 pregnant women live in areas affected by the disaster, and 50 000 will deliver in the next 3 months, many of them in areas where the health infrastructure has been destroyed. US Congressmen Steve Israel and Joseph Crowley asked the present Bush administration to make a one-time grant to the United Nations Fund for Population Activity (UNFPA) to extend emergency maternity care to these women. The Bush administration has refused. "We are not able to fund UNFPA right now. The restrictions apply across the board until there's a change in the Chinese policies that UNPFA participates in", said Robert Hilton, a spokesman for the State Department's Bureau of Population, Refugees and Migration.

This political battle dates back to the first Bush administration when the president withheld $34 million from the UNFPA, even though a congressional mission had found no evidence of UNFPA support of coercive abortions in China. Like Joseph Goebbels in the Second World War, the religious conservatives in America believe that if they simply repeat the same lie again and again they will be believed – and sadly the tactic is working.

When the most powerful nation will not make money available for safe deliveries, it is difficult to get any nation to make money available for safe abortion when it is needed. In the case of the tsunami, the demand for abortion is likely to be low, but nevertheless there will be some women who have lost their husbands and will feel unable to continue the pregnancy they now carry. In many other disaster situations, however, rape is a tragically common occurrence. In wars it is common to kill the men and deliberately rape the women, as is happening today in Dafur, Sudan. In the aftermath of war, as we have seen recently in parts of Africa, 'peacekeeping' troops sometimes coerce women to have sex. Women may give sex to an occupying power in desperate attempts to secure food for their children and themselves. However, even in Liberia, where a restrictive abortion law permits safe termination in cases of rape, neither the national government nor the international community has had the courage to offer safe abortion. In contrast to the difficulty of doing a Caesarean section in a disaster relief situation, first-trimester abortion with a manual vacuum aspiration kit could be performed safely in any refugee camp in any part of the world.

The horror and sadness of the tsunami disaster has triggered a massive international response, as photographs of piles of corpses and the stories from survivors arouse the sympathy of the world. In contrast, barely noticed is the silent tide of maternal deaths in many countries. Over twice as many women will die this year from childbirth and unsafe abortion as there were men, women and children drowned on 26 December 2004. Moreover, these deaths occurred in the previous year and will occur in the next. This metaphor of the silent tide is not in any way intended to demean the scale of the tsunami, but it does provide a measuring stick for thinking about an even bigger and seemingly perpetual tragedy.

The pain of a family when a woman dies of haemorrhage is no less than when she is drowned. The loss of the young mother to unsafe abortion complicates the family's economy as heavily as having a house swept away. Afghanistan has an estimated 16 000 maternal deaths annually[2] – even when the shooting stopped, the deaths did not.

In 1970 the international community launched the Safe Motherhood Initiative. In 2000 the Millennium Development Goals set a target of reducing maternal mortality by 75% between 1990 and 2015. Unless there is a radical change in policies and funding there is no way that this target can be met. Approximately half the deliveries that take place on this planet are not attended by a trained person. It is in these 65 million births that most of the deaths and injuries occur.[3] In countries where abortion is illegal, deaths from unsafe abortion account for between a quarter and half of all maternal mortality. The United Nations Children's Fund (UNICEF) reminds us that "… 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

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disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong."[4]

A Western woman has a 1 in 1000 to 1 in 5000 lifetime chance of dying in childbirth. Given high parity and greatly increased risks of death with each pregnancy, women in Africa have a 1 in 16 lifetime chance of death from pregnancy, childbirth or abortion.[5]

Several steps could be taken to turn back this tide of deaths. The first is to satisfy the unmet need for family planning. According to the World Health Organization, 123 million women around the world, primarily in developing countries, who have expressed their desire to space or limit their births, are not using contraception.[6] When contraception is available, it is older, high parity women and very young women who adopt it first. Studies in Sweden suggest that between one-tenth and one-third of the decline in maternal mortality that took place in the 20th century was due to the adoption of family planning, and the remainder to improved obstetric care.[7]

Second, it is impossible to have a low maternal mortality without access to safe abortion. Hospital-based studies show that unsafe abortion and complications have been the cause of up to 50% of maternal deaths in sub-Saharan Africa.[8]

Third, there is a need to proceed from emergency obstetric care to what might be called community-based obstetric care. The Gates Foundation, the International Federation of Gynecology and Obstetrics and other institutions are striving to increase the number of women who are attended by a trained person at delivery, but progress is likely to be slow.

Fortunately, much more can be done to help women in remote situations than was previously thought. The non-profit organisation Venture Strategies for Health and Development, working with the Bixby Program in the School of Public Health, University of California, Berkeley, is assisting medical colleagues in Africa and Asia in making the prostaglandin misoprostol available to traditional birth attendants to stop postpartum haemorrhage in home birth settings where most of the deaths occur. The Johns Hopkins School of Public Health has taken this one step further and conducted a study in Indonesia where women were given misoprostol to self-administer at the time of delivery. Using this remarkable off-patent drug that doesn't need refrigeration and thus can be used where clinics are out of reach, both projects have been successful, opening the door to large-scale reduction of the largest cause of maternal mortality worldwide.

Given the rapid growth in the number of young fertile women, it is possible that more women will die from pregnancy, childbirth and abortion in the current decade than in any other in human history. With steps that we know how to take, we should be able now to roll back the silent tide of maternal death. We should also be able to take sensible steps to help the women suffering in disastrous circumstances.

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