THE BUSINESS OF CHILDBIRTH PAPER PRESENTED: 22ND ICM CONGRESS, KOBE, JAPAN

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Childbirth has traditionally been labelled as the business of women. If this is so, why are so many women disadvantaged in a business they are said to own?

A business in which they are both the consumers and the major providers that has become notable in the developed world for the attention the media has given to issues related to women gaining control of their birthing experience, and midwives to gaining equity in the decision making processes of their nation's health care services. These debates have been long and very audible.

At the same time in the developing world there has been revealed a most appalling loss of life and trauma which seems to have been let happen because few took note of how much a liability it was for the women to be engaged in their own business.

Now the world's health care and professional organisations are seeking to understand, correct and redirect the business so that the outcomes are improved.

This is a multinational business and as in all such activities the factors which can influence the results achieved are often unique to each country, but much can be learnt form the experience of others.

The direct causes of maternal mortality and morbidity are well known, they are the same as were evident in the developed countries four decades ago. We know that access to trained health care providers and appropriate responses to conditions such as obstructed labour, haemorrhage and toxaemia can save lives.

Yet in many developing countries women continue to die in their thousands, and they continue to be damaged for life in the childbirth process. It is the women who are forced to use 'illegal' abortions to control their fertility. And, it is women who are mostly the traditional birth attendants and midwives. Occupations often not aspired to by educated women because of the low status given those who attend birth.

In these countries it is rare for the women to have control of the provision of health care and education services, they do not own the land they farm, nor do they as young girls gain adequate nutrition nor access to basic education.

For what we take for granted in the most developed countries is not so in the least developed where the male child is the most favoured "since the girl is regarded as a 'temporary' visitor in the family and destined to become part of her eventual husband's household, parents spend money on her with reluctance".[1]

The potential for survival in some areas in South Asia can be illustrated by the situation in Pakistan where "there are 910 females per 1000 men, the lowest national sex ratio in the world and these figures have worsened over the past twenty years."[2]

The Maternal Mortality Rate (MMR) for that country is estimated to be 600-800 per 100,000 live births.

In a region where 27⅝ of the worlds' births and half of all maternal deaths occur Sri Lanka stands like a beacon beckoning the women of the region to better opportunities for life.

Sri Lanka had in 1986-1988 a primary school enrolment for females as a percentage of males of 97%, whereas in Pakistan it was 55%.[3]

The MMR in this country is less than 100 per 100,000, such better outcomes are attributed to later marriage, lower fertility and attendance at 85% of the births by trained people.[4]

It should also be noted that the secondary school attendance of female sin Sri Lanka is 110% of that of males.

These are important indicators of how we can improve performance in our business. While women are both the main consumers and providers in the childbirth enterprise they also remain two thirds of the world's illiterates, and girls form six tenths of the world's 100 million children who do not have access to primary school.[5]

While women remain so disadvantaged there would seem to be little chance of this Confederation and the other organisations like minded achieving the Safe Motherhood objectives for this decade.

For it is with increasing literacy and education that women achieve lower levels of fertility, higher levels of family health and thus better maternal and infant outcomes. Without access to education, and there are projections that the adult illiteracy rates will increase from 50% to

60% by the year 2000[6], women will continue to be denied access to skills and knowledge by which they could, change the quality of their daily existence, manage their fertility, contribute better to priority setting in the use of limited resources in health care systems, participate in the development of their nations.

However, there are other obstacles the women have to overcome if the outcomes in childbirth are to be improved especially in societies where the male dominates decision making. Armstrong[7] and Sparkes[8] independently both refer to the inability of women in different parts of Africa to gain assistance, even when their life is at risk if their husband is absent, or does not agree to help being sought.

Further if the family is poor it may well be that they can not afford the fees needed to pay for more skilled attention. We who live and practice in countries where there are universal health care systems can not easily comprehend the inequity which occurs in health care in most countries of this world.

Marilyn Waring in her book 'Counting For Nothing'[9] states "Moral values combine with economic ones to ensure enslavement to inadequate health". Further she argues that because the system used for measuring production and growth throughout most of the world, the United Nations system of Nation Accounts, does not recognise the contribution of what is generally seen as womens' work to a country's economic status, the basis on which this rests is distorted.

For there is no recognition of the world of women as primary care givers, subsidence farmers, manufacturers of goods which are sold or exchanged to ensure the family is fed. yet it is generally acknowledged that women grow about half of the world's food and work longer hours than men.

These women live in countries where the so called Third World Debt crisis impacts in the daily lives of families. Belong to nations where the military spending often far exceeds that expended on education and both of those have resource allocations that are greater than that for health services. They also live in countries where 75% on average of those meagre health funds are spent on urban hospital based services which serve only a proportion of the poor.[10]

There is still an unfortunate trend evident in the developing countries for the latest in medical technology and pharmacology to be imported for use in these hospitals without consideration as to whether its use can be sustained, or if it can really be afforded.

According to the Director General of WHO "Governments are increasingly aware that dependence of health ministries on foreign currency jeopardises the smooth running of services."[11]

Universal access to appropriate technology is highly desirable. Midwives should concern themselves with gaining knowledge of and assessing what is available then contributing to its orderly introduction into the maternity care services in their countries.

What does require examination is the process by which decisions about what is to be introduced and by whom they are made.

We are all well aware of the bad press some of our colleagues in developing countries received in the lead up to the introduction of the WHO Code for the Marketing of Breast Milk Substitutes.

I have yet to read much about the way medical decision makers and providers are influenced by the multinational firms that sponsor international meetings, promote their wares at professional gatherings and support medical research activities and professional publications with advertising. I believe this insidious selling of goods to medical practitioners who are striving to gain recognition form their colleagues in the developed world is just as questionable as that which created the need for a WHO Code on Breast Milk Substitutes.

It is regrettable when personal economic imperatives clouds the professional judgement of any health care provider and in this the poorly paid can be more vulnerable. Job security does not always mean an adequate income is assured for some of our colleagues.

Economic considerations can not be overlooked in any discussion on the business of childbirth. Whether it be in the rates the professionals are paid, the remuneration that a TBA can expect from her clientele, or the cost of providing an effective health care worker closer to where the women can readily access their skills.

What concerns me is the achievement of a business strategy that defines the route by which sufficient numbers of the appropriately trained practitioners will be placed where they are needed with the personal economic security they must hae if they are to stay there.

The ability of some health care services to do this must be questioned. There is increasing evidence of a rising level of unemployed medical practitioners in some of the less developed countries, at the same time increasing dependence is being placed on TBA's to improve maternal outcomes, while there is little evidence of real commitment to increasing the numbers of professionally trained midwives despite the efforts of this Confederation.

The cultural values that ascribe to those who attend others in childbirth an inferior status are not easily overcome. Nor are the realities of limited access to a basic education without which there can be no midwifery training of any depth.

Unless this situation is reassessed little will be achieved, for in the developed countries improvements in maternal outcomes were achieved in an environment where the ratios of nurses and midwives to doctors was high and the general education of the women enabled them to increase their share holding in the business of childbirth.

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Director — Board of Management International Confederation of Midwives

Congratulations are extended to Margaret Peters on her election as the Director of the Board of Management, ICM.

This appointment is for a term of three years and will require Margaret to undertake several trips per year to ICM Headquarters in London to oversee the activities of the Confederation.

Margaret's appointment acknowledges her involvement in widwifery practice and education both on a National and International level. Her previous professional roles include:—

Honorary Treasurer — Midwives Association of Victoria 1978-83

Inaugural President — National Midwives Association 1978-83

President, International Confederation of Midwives 1981-84, Deputy Director, Board of Management — 1984-87.

Margaret was awarded the Medal of the Order of Australia in 1985 for services to midwifery practice and education.

Her other professional commitments include:

Honorary Treasurer — Centaur Nurses memorial Educational Trust

Vice President — Florence Nightingale Committee, Vic. Branch

Member — expert Panel on Women's health National Health & Medical Research Council

Member of the Management Committee, Health Issues Centre, Vic.

Margaret Peters with the Australian Delegates Cynthia Turnbull, Lorraine Wilson and Judith D'Elmaine after her election as the Director — Board of Management, ICM.