

## Editorial

# The gender lottery: maternal mortality in rich and poor nations

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Welcome to the first issue of Volume 6. Readers will have noticed that we have made a slight alteration to our title, which is now *Diversity in Health and Care*. The small change in the title allows us to re-focus our commitment to the equitable provision of healthcare and services for members of a wider range of social groups and settings in all countries around the world. This will enable us to provide a platform for papers about diversity in a wider field that encompasses race, culture and ethnicity, sexual orientation, gender, migrants and ethnicities, sexual orientation, gender, migrants, carers, disabilities (including physical, communication and learning disabilities), spirituality and underserved or marginalised populations. We feel sure that our readers will welcome this broader scope and continue to support us. For those who wish to contribute, our recent call for papers invited articles about qualitative or quantitative research, or debates about health, care or educational issues relevant to those themes. We particularly welcome multi-professional perspectives, studies which highlight the views of service users and carers, and papers that explore the international dimensions of diversity across and within cultures. Papers may take the form of:

- *research papers* that address any aspect of diversity, including evaluative studies and methodological debates
- *practice papers* that provide examples of culturally competent practice, or which address the practicalities, policy or managerial aspects of delivering services to members of diverse groups
- *education papers* that are concerned with improving or evaluating education or training of health and care professionals to address diversity concerns, whether during initial training or as part of continuing professional development
- *debate papers* that address key issues in diversity, or which focus on under-researched topics

- *knowledge-sharing reports*, including reviews of books, websites, videos and other resources, and papers about specific initiatives to improve practice.

Further information and guidelines for authors are available at [www.radcliffe-oxford.com/journals/J18\\_Diversity\\_in\\_Health\\_and\\_Social\\_Care](http://www.radcliffe-oxford.com/journals/J18_Diversity_in_Health_and_Social_Care)

Change is, naturally, a central theme in this first issue for 2009, and March is traditionally a month in which to think about women. International Women's Day on 8 March commemorates the struggles of women in every society for human rights, civil liberties and equality in all aspects of life. Even in wealthy, developed societies these struggles are far from over, but the situation has become less acute and it is easy to forget how life used to be. In the UK, within living memory, women fought for and won the right to vote (Equal Franchise Act 1928), the right to equal pay for equal work (Equal Pay Act 1970), the right to obtain a mortgage to buy property and, in 1980, the right to obtain credit, allowing them to pay for goods in instalments, without a male guarantor (University and College Union, 2009). In 1981, two women successfully prosecuted a wine bar in London where staff refused to serve them because of their gender (Equal Opportunities Commission, 2000). As a result, in restaurants, women are now served the same size portions as men and can pay their own bills, and no waiter or barman can refuse to serve them or to accept their money on the grounds of their gender. It is now illegal to dismiss women because they have become pregnant, and women have gained the right to equal pay for equal work and admission to many previously men-only institutions and occupations (Equal Opportunities Commission, 2000). In many ways both women and men are better off as a result of these changes, but there is still much to be done as women of each new generation negotiate their rightful place in society and contribute their much needed skills.

One aspect of life in developed countries such as the UK that has improved immeasurably is maternal mortality, the death of a woman during or within 42 days of the end of a pregnancy, irrespective of how long that pregnancy lasted (Graham *et al*, 2008). Such deaths may be directly related to the pregnancy itself or occur as a result of complications. The most common causes are thrombosis, haemorrhage, ectopic pregnancy, sepsis and pregnancy-related hypertension occurring in the third trimester or shortly after birth (United Nations Children's Fund, 2009). Other deaths may occur when a pre-existing condition, such as heart disease or diabetes, is exacerbated by pregnancy or by some other factor such as substance abuse, exposure to violence, or poor standards of care (Healthcare Commission, 2006).

The most recent figures, from 2005, show that across all developed countries the average maternal mortality rate (MMR) is 8 per 100 000 live births, with Ireland having the lowest rate of all, at 1 per 100 000. These improved figures are associated with the provision of universal antenatal care and the availability of skilled professionals to attend women during childbirth (United Nations Children's Fund, 2008). In the developing countries a very different picture emerges. Although large numbers of women do manage to give birth without professional help and survive, 'having a child remains among the most serious health risks for women' (United Nations Children's Fund, 2009, p. 2). Women in developing countries are 300 times more likely to die from the complications of pregnancy, complications that are treatable, than their counterparts elsewhere (United Nations Children's Fund, 2009). Current estimates suggest that, in 2007, 9.2 million women died as a result of events associated with pregnancy (United Nations Children's Fund, 2009). The United Nations Population Fund ([www.unfpa.org/mothers/index.htm](http://www.unfpa.org/mothers/index.htm)) states that a woman dies every minute from the complications of childbirth, which means that at least one woman has died since you began reading this article.

The full scale of the problem is difficult to assess. For example, some areas lack the infrastructure needed to record data about pregnancies or other health-related information. Data may be under-reported if practitioners fear reprisals, and deaths may be misclassified in cases where there was a pre-existing condition (United Nations Children's Fund, 2008). However, such difficulties were noted and overcome when addressing other health problems such as HIV/AIDS, but, by comparison, the monitoring of maternal mortality rates seems to have lagged well behind. The current trend towards 'results-based financing of maternal, neonatal and child health programmes by donors is now adding further incentives to improve data' and provide a clearer picture (Graham *et al*, 2008). It is hoped that this will lead to improvements in monitoring.

However, the fact remains that women are dying. Around 50% of maternal deaths occur in sub-Saharan Africa and a further third occur in South Asia (United Nations Children's Fund, 2009). For every woman who dies, a further 20 women suffer pregnancy-related illness or develop long-term, stigma-inducing problems, such as uterine prolapse or fistulae, that lead to social exclusion (United Nations Children's Fund, 2008). There are multiple reasons for this situation. Women who live in remote and rural areas worldwide are less likely to have access to healthcare. Poverty, associated with poor nutrition, is also a key factor, especially in sub-Saharan Africa and south Asia, and 'is critical in Bangladesh, Eritrea and India' (United Nations Children's Fund, 2008, p. 6). Early marriage, in childhood or before the age of 18 years, persists in sub-Saharan Africa and South Asia, resulting in girls becoming pregnant before they reach physical maturity (United Nations Children's Fund, 2008). Minority or low social status may restrict access to care, and services for pregnant women may be patchy or non-existent.

Two factors stand out as particularly important. The first is education. Educated women are better equipped to support themselves. They are more likely to seek help during pregnancy, and 84% of those who have completed secondary education will be attended in childbirth by skilled helpers. For less than half of those without education will this be the case. Moreover, educated girls are likely to defer marriage and pregnancy until adulthood, and their children are far more likely to survive (United Nations Children's Fund, 2009).

The second factor is the status of women in society. We have noted elsewhere that women do not have full human status. They are bought and sold as cash crops in 137 destination countries (McGee and Johnson, 2007). Moreover, in many countries, especially in sub-Saharan Africa, they have little opportunity to speak for themselves. Men decide what women may receive, based on men's ideas of what should happen, and trivialise women's concerns. Gender apartheid denies women a voice in decision making about matters that concern them. Strict segregation rules and cultural taboos isolate women both from men and from each other, making collective action impossible, especially if the men disapprove of such action. For example, Sharia police in Kano, Nigeria, have recently blocked an attempt by women to hold a protest about the treatment of divorced women. The police argued that women protesting in the streets were 'an embarrassment', un-Islamic, and therefore banned (BBC News, 2009). To learn of this, from a part of Africa where women have historically been highly independent and, indeed, where Queen Amina of Zazzau (1533–1610) was one of the first Islamic rulers and one of the greatest rulers of the Hausa Empire, is particularly

disturbing. (Younger readers may like to know that she is also said to have been the model for the television character Xena – Warrior Princess!).

Regimes that deny girls an education, in defiance of the 1989 Convention on the Rights of the Child and many other international rulings, prevent any hope of change. The lack of education perpetuates ignorance, so traditional practices that are harmful continue unchecked. Girls are unable to enter the professions that could bring about change, such as obstetrics, public health, nursing, and midwifery, to name just a few. They lack the confidence, knowledge and articulacy to enter politics, and so are unable to challenge the system.

Yet there is some hope. The Cameroonian film *Sisters in Law* (Longinotto and Ayisi, 2005) scooped the Prix Art et Essai at the Cannes Film Festival. In documentary format the film demonstrated what can happen when women use the laws of their country to claim what is rightfully theirs. Challenging the system calls for hard work and persistence, but it also shows how those who treat women unjustly are often weak cowards. In another example, Nigeria, the most populated country in Africa, with 6 million births in 2007 alone, has launched an Integrated Maternal Newborn and Child Health (IMNCH) strategy to improve the health of women. This strategy has three phases, each of which is to be delivered over a three-year period. The first phase focuses on 'identifying and removing bottlenecks, while delivering a basic package of services using community-based and family-care strategies', with an emphasis on combating malaria. 'The second and third phases of the IMNCH will place greater emphasis on building health infrastructure' (United Nations Children's Fund, 2009, p. 19).

Much depends on the financial situation and the political will to see this strategy through to the end, but one developing South Asian country provides an example of what can be achieved. Sri Lanka reduced its MMR from 340 per 100 000 live births in 1960 to 43 per 100 000 in 2005. The key to success seems to have been a combination of factors, including universal healthcare and social services for those in poverty, and the empowerment of women 'through education, employment and social engagement', which resulted in a sharp rise in literacy rates among women (United Nations Children's Fund, 2009, p. 21). In 2007, 98% of all births took place in hospital and 99% of women were attended in childbirth by skilled practitioners. As in Nigeria there are financial problems and a shortage of health professionals, but both of these examples demonstrate that change is possible.

We begin this issue with the hope of change with regard to another matter. Aamra Darr's editorial addresses the problem of disability among Pakistani people, which has been linked to consanguineous marriage. Pakistani people are blamed for this aspect of their

culture by those who see consanguineous marriage as wilfully negative behaviour that results in a huge burden for the taxpayer, that is, the non-Pakistani majority, white people. This particular strand of racism is not new and, as Darr points out, it continues to be used as a pretext for denying people the health and social care services that they need. 'They've done it to themselves', the argument goes, 'so why should we do anything?' Consanguineous marriage is customary in a number of societies, especially those that do not have a welfare state and where the family is the only means of support in difficult times. Family members can be prevailed upon to help, whereas others may not feel so obliged. Moreover, marriage within the extended family can be particularly beneficial to women in providing lifelong support. As Rozario (2005, p. 189) has pointed out, consanguineous marriages 'may be seen as desirable to maintain bonding and solidarity with relatives ... [people feel that] it is better to "marry your own" so that individuals know that they can rely on their in-laws and that their behaviour and values will be similar.' However, it must be recognised that certain conditions are more prevalent among specific ethnic groups, for example, coeliac disease among the Irish, and thalassaemia among Pakistanis. Conditions that bring suffering and other severe burdens require care and thought. No one wants to deliberately inflict such difficulties, and Darr makes it clear that Pakistani families are beginning to recognise the need to access and use information about genetic risks. In all cultures and societies such moves are challenging. Secrecy about genetic disorders is understandable if the condition can seriously affect 'normal' children's chances of marriage (Rozario, 2005). The stigma and shame of disability and inherited conditions can be considerable, resulting in a state of denial: 'there's nothing like that in our family'. Refusal to discuss such matters, in the mistaken belief that 'if something is not talked about, it won't happen', does not help either. Clearly change is needed on both sides, and both health professionals and Pakistani families need to make some adjustments. Pakistanis are facing up to the challenges of genetic disorders, and practitioners must do the same with regard to racist, culture-blaming attitudes.

Our first research paper continues the theme of change. In many parts of the world, the health and well-being of First Nations and other indigenous peoples has suffered considerably as a result of colonisation. In Canada, according to the First Nations Comparable Health Indicators (Health Canada, 2005), First Nations and other indigenous peoples have lower life expectancies than the majority, white population, namely 68.9 years for men and 76.6 years for women, compared with 76.3 years and 81.8 years for white men and women, respectively. Fertility rates are high, at 23 births per 1000 members of the population. First Nations and other indigenous peoples have a 20% higher

likelihood of having a heart attack and a 50% higher likelihood of suffering a stroke than members of the majority population, but cancer mortality rates are lower. Suicide rates are high, three times the average among the majority population. The incidence of type 2 diabetes is three to five times higher among First Nations people, and rates are increasing among the Inuit. Tuberculosis infection rates are 8 to 10 times higher than in the majority white population (Health Canada, 2005).

Cultural competence is an important issue in addressing the health needs of First Nations and other indigenous peoples. The National Aboriginal Health Organization (NAHO) (2008) argues that many First Nations and other indigenous peoples have negative experiences of health services largely because of cultural differences. As in New Zealand, health service culture and practices mean that many First Nations and other indigenous peoples do not feel safe under the care of health professionals. Consequently, the National Aboriginal Health Organization (2008, p. 8) argues in favour of cultural safety, adding that 'the provision of culturally safe care involves lifelong learning and continuing competence. Cultural safety is the outcome of culturally competent care.' Treating a patient in a culturally safe manner requires changes in the ways in which professionals communicate with patients. They must 'learn to not use jargon, technical or academic terms, and explain things simply and clearly. However, it is important that plain language should not be used in a way that makes the patient feel they are considered less intelligent' (National Aboriginal Health Organization, 2008, p. 11). Professionals must find ways to include patients in decision making and accept that 'clients/patients may have beliefs about causes and cures that do not fit with established medical views' (National Aboriginal Health Organization, 2008, p.11). Cultural safety also applies to individuals from First Nations and other indigenous cultures who wish to enter the health professions. Training establishments should provide culturally-safe environments that enable students from these minority backgrounds to achieve and develop the skills required to care safely for members of their own communities as well as for the majority. Meeting the National Aboriginal Health Organization's (2008) agenda will require a considerable amount of work, but we are pleased to present a paper by Roger Walker and his colleagues which outlines the development of a culturally safe approach to healthcare in Northern Ontario.

Our second research paper continues the focus on minority ethnic groups. Fran Badger and her colleagues present an examination of end-of-life care for older adults. This is an important and growing issue. As a study by Anwar (1979) demonstrated 30 years ago, economic migrants travel with the expectation that they will return home in a few years' time, when they

have made their fortune. They plan to work in a wealthy country for a few years and then return home and buy a house, a farm, a tractor, purchases that will enable them to live comfortably, and perhaps even give them some increased social standing. Unfortunately the reality is that, in every developed country, immigrants tend to end up doing the jobs that the local people do not want to do, jobs that are not well paid. Time passes, relationships form, children are born but the dream of going home persists, even though that home will have changed beyond all recognition (Anwar, 1979). The dream means that many migrants do not think about what will happen when they are too old or too infirm to cope. In the host communities, service providers are often ill equipped to meet the needs of the new elderly, and fall into the trap of believing that their extended families will do everything for them. Badger's paper highlights how little is currently known in the UK about the needs of older members of black and other minority groups when they are no longer able to cope alone, and it questions whether professionals are equipped to provide culturally appropriate care.

Our third research paper focuses on an under-researched topic, namely conflict management by nurse managers working in Oman. This is an important issue for several reasons. First, like several other countries in the region, Oman relies heavily on expatriate nurses to provide care, and consequently working teams are likely to be very diverse. As Zaid Al-Hamdan's paper points out, strategies for resolving conflict are closely linked to cultural values and beliefs about how people should behave, and some will be more suited than others to healthcare settings. Nurse managers need a repertoire of appropriate strategies that enable them to anticipate conflict and either prevent it or resolve it as quickly and effectively as possible. Second, Oman, like Saudi Arabia, is pursuing a policy in which expatriate workers will eventually be replaced by nationals. At present this means that Omani nurses are often promoted to posts for which they are not adequately prepared in terms of dealing with conflict. It is hoped that Zaid Al-Hamdan's research will enable them to gain some insight into different conflict management styles, and to develop their own, Omani-based approaches to management. Finally, there is limited research from Oman, and from other neighbouring countries, that addresses healthcare management from an Arab perspective, and we are pleased to be able to provide a platform for one of the first studies of this kind.

Our next two papers are intended to provoke debate. First, Suki Desai draws attention to an aspect of modern life that is often taken for granted. We are all aware of the presence of closed-circuit television (CCTV) in our streets, shops, airports, and many other places. Those in power insist that these cameras are present to ensure our safety. In Darlington, for

example, the Police and Public Safety website ([www.darlington.gov.uk/Public+Safety/CCTV.htm](http://www.darlington.gov.uk/Public+Safety/CCTV.htm)) informs us that CCTV was 'set up to respond to public concerns about high levels of car crime and public disorder, and the facility has continually grown, diversified and developed to include several residential areas.' Too right it has. Diversification means that CCTV monitoring is now not simply a local affair, and information can be collected for other organisations, such as railway or bus companies. The actual and potential uses of CCTV-based information are a major cause of concern, especially as it does not seem to serve the stated purpose of promoting public safety. Wadham (2002) has argued that the UK Home Office's own research showed that, although CCTV had a positive effect in helping to reduce crime in car parks, this was not the case in relation to other types of crime or locations, and better street lighting was far more effective. The House of Lords (2009) has recently expressed considerable unease about the development of surveillance systems, including CCTV. Their report recommends 'that the Home Office commission an independent appraisal of the existing research evidence on the effectiveness of CCTV in preventing, detecting and investigating crime (and) that the Government should propose a statutory regime for the use of CCTV by both the public and private sectors, introduce codes of practice that are legally binding on all CCTV schemes and establish a system of complaints and remedies' (House of Lords, 2009).

If CCTV is a contentious issue in everyday life, it should be of even greater concern when used in settings where people are at their most vulnerable. Desai's paper explains how the use of CCTV has spread like ivy through psychiatric hospitals. There is no plan behind this, and no clear idea as to how it should be used or why it should be necessary. The potential for infringement of patients' rights, and indeed those of staff, is considerable, and we hope that Desai's paper will encourage others to consider the implications of using CCTV in their own practice settings, especially in the light of the House of Lords' recommendations (House of Lords, 2009).

Our final paper concerns the rights of another minority group, those whose sexual preferences and identities differ from the majority. We have written elsewhere about the prejudice directed towards people who are lesbian, gay, bisexual or transgendered (LGBT), and the difficulties that they experience as a result of such discrimination (McGee and Johnson, 2006). As with the other topics covered in this issue, there is a depressing history here of social exclusion, fear and suffering, which we hope is now drawing to a close. Lesbian and gay people can now, in some societies at least, live openly and hold prominent public positions. However, transgendered people still face discrimination and prejudice, starting in their own families.

Bob Cant's discussion of legal reforms shows that, in the UK at least, considerable progress has been made. Health and social care professionals have a responsibility to ensure that their practice keeps pace with these reforms by actively engaging with LGBT communities in order to ensure that services meet their needs.

We close this issue with our two regular features. In *Did you see?*, Pablo Ronzoni takes us right to the heart of examining difference, how we construct 'the other' as someone exotic whose beliefs are viewed as quaint, childlike or deviant. Ronzoni challenges the ways in which western ideas about mental health and illness are applied to those of non-western origin, and calls for 'better ways of combining the helpful aspects of categorisation with the personal narratives that patients bring with them [because] ... The individual stories that patients have is what makes mental health such a compelling clinical field to work in' (Ronzoni, 2009). Our *Knowledgeshare* section then presents a varied and useful collection of items for anyone with an interest in diversity.

We hope that 2009 will be a good year for all our readers, and we thank you all for your continued support in making *Diversity in Health and Care* a success.

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