

Maternal Mortality in Chiapas: An Unfinished Story

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As part of Mexico's strategy to achieve Millennium Development Goal 5.A (reduction of maternal mortality by $\frac{3}{4}$), efforts have been made to increase the number of births occurring in institutional settings. These efforts were intended to improve a key indicator for Goal 5: the number of deliveries "attended by skilled health personnel." The practical consequence of these efforts has been that hospitals are seeing ever-increasing numbers of normal deliveries. As an unintended consequence, the quality of care provided to true obstetrical emergencies has decreased. This problem is particularly severe in those regions of Mexico, like Chiapas state, that are characterized by high levels of poverty and social marginalization. Maternal mortality rates in these areas are high. Importantly, most of these maternal deaths occur *in the hospital*.

With the goal of promoting deliveries attended by "skilled personnel", obstetrical services at the primary level have been dismantled, and there has been a tacit prohibition of deliveries by traditional midwives. The result has been that the reference hospitals have been overwhelmed with low-risk

pregnancies and cannot adequately manage the volume of deliveries.

A case in point is the San Cristobal de Las Casas Regional Hospital, the reference hospital for the Chiapas Highlands or "Altos." The Highlands are an area where a large percentage of the population is indigenous. It has high levels of poverty and social exclusion, a remarkable geographical dispersion, and a history of serious health deficits. While the hospital receives many true obstetrical emergencies from the Highlands, it also sees many women whose deliveries could have been managed at a lower level of care.

A case history – involving a maternal death – illustrates both the technical and cultural problems with the medical services in the Chiapas Highlands, where the need to attend to a growing number of normal births has overwhelmed the existing trained personnel. The result is that obstetrical emergencies are not handled according to established protocols in a hospital that does not have an intensive care unit.

In October 2013, Susana, a 26-year-old indigenous (Tzotil) woman from Cruztón village (in the San Juan Chamula municipality), died at San Cristobal de Las Casas Women's Hospital. Everything seems to indicate that her death was due to medical malpractice. She was initially misdiagnosed, had a late caesarian section, and her gallbladder was later removed. Inadequate post-op care led to this young women's highly avoidable death.

Susana's case resulted in a lawsuit brought by her family with the support of civil associations. It is alleged that her death was not just the result of medical errors; both Susana and her family were victims of the discriminatory treatment that characterizes the cultural inadequacy of a hospital that primarily serves indigenous women.

This lawsuit exemplifies the strategic use of litigation to trigger discussion of important social issues: in this case, the need to strengthen the healthcare infrastructure and its technical capacity to

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handle normal deliveries at the primary care level, the need to improve training and supervision of medical personnel, the need to develop technical guidelines for intercultural healthcare delivery, and finally, the need for an Intensive Care Unit in the hospital in question.

However, Susana's case raises other issues. There needs to be a discussion of the public policies that overburden hospitals with normal births, the increase in unnecessary caesarian sections, and the growing exclusion of traditional midwives within the public healthcare system. In a setting where intercultural work should be the norm, professional medical personnel need to work alongside midwives to jointly assist with normal births. Instead, we see a growing proportion of hospitalized normal births and unjustified caesarean sections. Pregnancy thus becomes fertile ground for over-medicalization, cases of mistreatment during labor, and technical errors such as the ones that led to the death of Susana.

According to official statistics, at least 60 maternal deaths occurred in Chiapas in 2011. Of these, 50% were indigenous women; in Chiapas only around 27% of its population is indigenous. 67% died in a public clinic or hospital, and another 8% died in a private clinic or in a hospital run by one of the social security institutions. 43% had delivered inside a public clinic. In 2012, there were 68 maternal deaths registered.

What happens when the hospitals are overwhelmed? Since the capacity to attend births at the primary level has been diminished, women have no choice but to use traditional midwives. This means we have little information about a large number of births.

1. The primary care level remains unprepared (both in terms of training and of supplies) to deal with deliveries that could be cared for there.
2. Hospital services are spent dealing with the high number of births that could have been attended to by midwives or at the primary care level. This reduces the availability of hospital personnel and resources for those women that need them the most. This is responsible for the high percentage of deaths that happen inside hospitals.
3. Hospitals don't have the capacity to care for women according to their own unique social and cultural characteristics. This fact alone

demonstrates that the quality of care is inferior. This issue affects both medical care and issues such as food (both for women and their families).

While it is true that healthcare coverage by the public health sector in Mexico has increased considerably, regional inequalities have deepened. This is true not only in terms of coverage but also in terms of the quality of care provided by such services. In this context, the process of institutionalizing childbirth has been implemented in parallel to the dismantling of the capacity to manage births at the primary care level. This has resulted not only in the already described issues, but also in the sustained increase of unjustified caesarean sections (the 2012 National Health and Nutrition Survey found that 45% of births were surgically delivered that year). In Chiapas, a large proportion of maternal deaths are potentially avoidable by such measures as stabilization at the primary care level before hospital referral. The lack of resources to pay for transport and deficiencies of primary care services (among other problems) contribute to the persistence of the high maternal mortality index in Chiapas.

Susana's death throws light upon a series of factors that need to be changed in order to effectively reduce the number of deaths amongst those women with obstetric emergencies who eventually reach the hospital. Some of these factors include technical problems and lack of adherence to established treatment protocols. However, other factors are more closely related to the lack of sensibility and responsibility on the part of hospital personnel, as well as inadequate supervision. In hospitals that serve a majority indigenous population, lack of cultural understanding, and frequent mistreatment of patients and their families contributes to mistrust which, in turn, results in delays or avoidance of hospital referral; this leads to frequent bad outcomes.

Less than a third of all women in Chiapas are indigenous. However, half of maternal deaths are among indigenous women. Nationally, only 16% of maternal deaths involve indigenous women. The increased risk of death experienced by indigenous women in Chiapas provides irrefutable evidence that inequality and discrimination are responsible for the seemingly never-ending story of avoidable maternal deaths. This will continue until policies and protocols are implemented that are both concrete and effective.

The World Health Organization has recommended that in order to achieve Millennium Development Goals 4 and 5 skilled health personnel should attend all births. However, in places like Chiapas there are simply not enough trained midwives. Nor has there been a coordinated response either to provide traditional midwives with the appropriate training or to allow them to work in close coordination with medical staff. Instead, traditional midwives have been explicitly prohibited from attending childbirths, limiting their function to that of companions and collaborators in the policy of indiscriminately sending both normal and complicated obstetrical cases to the hospital.

In 2012, the national rate of institutional deliveries reached 94%. In Chiapas only 60.5% of

babies were born in institutional settings. This means that at least 60,000 children were born outside of institutional settings. If all of these births occurred in hospitals, conditions in local hospitals would deteriorate and quality of care would suffer further.

Whatever public policies say, traditional midwives have continued and will continue to attend births. However, now they do so further away from supervision and training, and dominated by the perception that their work is clandestine. This makes it increasingly difficult to coordinate efforts among all concerned actors to seriously address and ultimately reduce maternal deaths.

