**[Pregnancy, before the flood](https://www.dawn.com/news/1713900/pregnancy-before-the-flood)**

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SUCCESSIVE governments in Pakistan have not prioritised the basic needs of the people. This continued neglect over decades has resulted in a population that is growing unabated, unhealthy, uneducated and poor. Those suffering the most among them are also voiceless so they quietly endure their kismet.

Emergency situations due to various kinds of disasters — natural, man-made and a mix of both — expose the inadequacy of a rickety infrastructure and exacerbate the travails of an already deprived people. But to truly understand the enormity of the challenge in the wake of this year’s flood, it is important to examine the dire state of various facets of human development in Pakistan even before the calamity. Consider maternal health, for example.

Women in general, and poor rural woman in particular, are the largest and most vulnerable group among us. All indicators of their health and social and economic condition are abysmal.

Women’s survival during pregnancy and childbirth is one such indicator. WHO’s estimate of maternal mortality ratio (MMR) in Pakistan for 2017 was 140. (For comparative purposes and reliability, let’s stick to this figure although the 2019 Pakistan Maternal Mortality Survey — or PMMS — using the verbal autopsy method gave a higher estimate for MMR at 186). What does MMR mean?

**Editorial:** [*Maternal mortality*](https://www.dawn.com/news/1576178)

In simple terms, it is a risk of maternal death per pregnancy, expressed as the number of maternal deaths per 100,000 live births. To put it into perspective, MMR in the same year for Iran was 16, Sri Lanka 36, China 29, US 19, UK seven, while in Norway and Italy only two pregnant women per every 100,000 live births were dying.

Yes, there are countries where MMR is higher than in Pakistan and it is also true that the trend in this country is positive as we have been able to lower MMR by more than half in around two decades, ie in 2000, our MMR was 286. But since MMR can be reduced by easily available medical interventions, even a ratio of 140 or 186 is extremely high for the world’s fifth-largest country. Moreover, different areas in Pakistan also show stark inequities. For example, the PMMS figure for urban MMR is 158 whereas for rural areas it is 199; likewise, for Punjab it is 157, but for Balochistan it is 298.

Even in ‘normal’ circumstances, pregnancy is a high-risk condition for women in Pakistan.

MMR is a telling indicator of women’s status in society, as well as their access to and the quality of healthcare available to them, especially at the primary healthcare (PHC) level. Maternal and newborn healthcare, unless integrated into the general healthcare system at PHC level in the context of universal health coverage, is neither sustainable nor would it improve MMR and neonatal and child survival. Patriarchy, misogyny, women’s low educational and economic status, poor healthcare system and an even worse PHC system, all contribute to high MMR.

From family planning, antenatal care and childbirth to caring for the newborn and raising a child through infancy and early childhood, at each step there are now proven interventions available which are simple and cheap. If effectively and consistently employed, they can ensure improvement in mother and child health. The tragedy is that despite known interventions we have poor indicators at each stage.

**Read:** [*Maternal mortality — Balochistan's women suffer in silence*](https://www.dawn.com/news/1139853)

As a student of public health, I have always believed that when preventable morbidity and mortality is not prevented, then somebody is responsible for it and must be held accountable.

To begin with, out of nine million pregnancies every year, 4m are unplanned. The use of modern contraceptive methods is very low at 34.5 per cent and, as a result, an average Pakistani mother bore 3.5 children in 2020. With an annual population growth rate of 2.4 (the Asian average is 0.92pc), Pakistan adds 5.2m people every year to its headcount — which is close to adding one Norway annually! At this rate of growth, there will be 350m of us by the year 2050.

A pregnant woman needs consistent care and support and WHO recommends eight antenatal care (ANC) visits to a health professional. However, in Pakistan, 45pc women do not visit a facility for ANC during the first trimester; 49pc have fewer than four ANC visits during their pregnancy. A healthy diet, daily iron and folic acid oral supplements, tetanus toxoid injection and an ultrasound at six months are some of the essentials of ANC. The National Nutritional Survey 2018 found 35.5pc of our pregnant women suffering from anaemia and 46.9pc had iron deficiency.

Anaemic and micronutrient deficient mothers give birth to weak and low birthweight babies. When already anaemic women lose further blood during childbirth, some go into cardiac arrest and do not survive. Improving haemoglobin levels of pregnant women is not rocket science. No less than 41pc of maternal deaths in Pakistan are caused by excessive blood loss during childbirth ie postpartum haemorrhage. Normal childbirth should preferably take place in a health facility at the hands of a skilled birth attendant (midwife, nurse or doctor). But in Pakistan 34pc births take place at home often carried out by unskilled birth attendants (65pc in Balochistan).

**Read:** [*Maternal and child health*](https://www.dawn.com/news/1506464)

According to World Bank figures for 2020, Pakistan has the notorious distinction of having the second highest neonatal mortality rate (NMR) in the world. NMR denotes the death of newborns during the first month for every 1,000 live births. Pakistan has an NMR of 40. Only Lesotho with an NMR of 44 is worse than us; and we are in the bad company of South Sudan which also has an NMR of 40.

The key reasons for high neonatal mortality include: preterm birth, low birthweight, asphyxia at birth and birth defects. Malnutrition of mother and child are key underlying contributing factors to high neonatal mortality.

I was actually planning to write this article on pregnant women in the flood-hit areas and the challenges in providing them proper healthcare. But as I started thinking about the topic, it became clear to me that I first need to present to the readers the state of our pregnant women even in ‘normal’ circumstances. Only then can we understand the impact of a public health emergency superimposed on this dysfunctional system. In my next column I will talk about pregnancy care in flood-affected areas through the example of an impressive response.

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