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Crisis in the Operating Room

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Afterward, they comforted each other with the blasphemy: “It was God’s will.”

It was the first pregnancy for Shazia Allahdita, 19. I was in the operating room at a public hospital here in Karachi as surgeons performed a Caesarean section on her to try to save her life.

As she lay unconscious under the anesthesia, doctors plucked a baby boy from her uterus and then labored to revive the child. “He has a heartbeat, but he’s not crying,” Dr. Aijaz Ahmed explained tersely as he gave the boy oxygen. “He’s not responding. I think he’s getting weaker.”

These dramas play out constantly in poor countries. One woman dies a minute from complications of pregnancy or childbirth somewhere in the world, and 20 times as many suffer childbirth injuries.

There’s no mystery about how to save these lives. Some impoverished countries, such as Sri Lanka, have succeeded stunningly well at saving mothers simply because they have tried. But foreign aid donors like the United States have never shown much interest in maternal mortality, and impoverished women are typically the most voiceless, neglected people in their own countries — so they die at astonishing rates. Here in Pakistan, 1 woman in 74 will die at some point in her life from complications during pregnancy.

Shazia’s suffering is typically unnecessary. It all would have worked out fine if she had gone to a hospital to deliver her baby. She wanted to. Her husband and relatives all agreed, when I interviewed them later, that she had had her heart set on delivering at the public hospital here. It’s also free, so long as supplies haven’t run out (other times, family members have to rush out to buy supplies).

But Shazia’s female in-laws thought that a hospital birth was a silly extravagance, and a young Pakistani woman is at the mercy of her mother-in-law and sisters-in-law. (In Pakistan, men are little involved in such decisions about childbirth.) It didn’t help that the in-laws resented Shazia because she and her husband, Allahdita, had breached tradition by marrying out of love rather than by family arrangement.

When Shazia went into labor, the family summoned a traditional birth attendant to help with the delivery. Hours passed. Nothing happened. Shazia asked to go to the hospital, but it was far away and would require what for them would be an expensive taxi fare of 300 Pakistani rupees, equivalent to about $3.75.

“If she went to the hospital, then every time the family visited it would be a long way to go and very inconvenient,” explained an aunt, Qamarunnisa. “It was so much easier to go to the local health post. It seemed easier.”

So the family eventually took her to a local clinic, where Shazia struggled to deliver for another 24 hours of labor. The family discussed taking her to the hospital, but the obstacle was the 300 rupee taxi fare. “If it hadn’t been for the money, she would have come here,” said Qamarunnisa.

But nobody wanted to pay. Shazia’s in-laws truly are poor, but it’s hard to imagine that they would have balked if it had been a man in the family who was in danger — or if they had known that Shazia was carrying a baby boy.

“If they had known it was a son, they would have come up with 500 rupees,” said Dr. Sarah Feroze, as her colleagues struggled to save Shazia and her baby.

Finally, some 30 hours after Shazia’s water had broken, an aunt paid for the taxi to the hospital. The doctors immediately saw that Shazia’s baby could not fit through her pelvis and rushed her into the operating theater for the C-section.

Shazia lived. The baby died.

I visited Shazia the next day. She was in a crowded, stifling ward. The power had gone out. Her bedding was soiled. She was crying.

Outside, her husband, Allahdita, was grieving but philosophical. “It is God’s will,” he said, shrugging. “There is nothing we can do.”

That’s incorrect. If men had uteruses, “paternity wards” would get resources, ambulances would transport pregnant men to hospitals free of charge, deliveries would be free, and the Group of 8 industrialized nations would make paternal mortality a top priority. One of the most lethal forms of sex discrimination is this systematic inattention to reproductive health care, from family planning to childbirth — so long as those who die are impoverished, voiceless women.

Thankfully, there is the dawn of a global movement against maternal mortality. Prime Minister Gordon Brown of Britain and the United Nations secretary general, Ban Ki-moon, are trying to work with the United States and other countries to hold a landmark global health session at the U.N. focusing, in part, on maternal health. If that comes to pass, on Sept. 23, it will be a milestone. My dream is that Barack and Michelle Obama will leap forward and adopt this cause — and transform the prospects for so many young women like Shazia.

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