

The obstinate maternal mortality ratio for Malawi: an Insult beyond the obstetrician! 'A Cri de Coeur'

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'In a human rights analysis, emergency obstetric care is not just one good idea among many. It is an obligation.'

LP Freedman

It is a medical tradition to think rather than to feel. Expressing feelings seems unprofessional and not appropriate in the medical profession. A consultant has to be a person to be relied upon and to be trusted because (s)he is not moved by emotions. The clinical judgement can be relied upon because the physician e? is all clinical objectivity, sound, cold and right.

While we do by no means say that there is anything wrong with reaching a clinical judgement and opinion on the basis of rational thinking and decisions based on evidence and carefully weighed clinical experience, we still want to ask for your compassion.

The latest maternal mortality ratio (MMR) for Malawi as published by the World Health Organization in 2005¹ shows a staggering MMR of 1800/100,000! (620/100,000 in 1996, 1120/100,000 in 2000). This is an unacceptable number! It should be headline news not only in Malawi, but also in all the major papers of this world: MMR in Malawi 1800/100,000!

This kind of MMR is almost unbelievable and certainly unacceptable! The more developed countries have MMRs of around 10/100,000 and most countries in the region have rates of around 200/100,000!² It is a reasonable question to ask whether an MMR as high as this is something to which the health service has actually contributed in some way. It does not seem to make evolutionary sense to have so many mothers dying, especially considering that many young children whose mothers have died are likely to die as well.

Historically the MMR is said to have been as high as 2,350/100,000 in medieval Europe.³

Research in the United States more than twenty years ago shows that the MMR in an American subpopulation where mothers refuse any obstetric intervention during childbirth is 872/100,000, which is much lower than our MMR.⁴

In the 1840's institutional MMRs of 9,900/100,000 have been reported in the University Clinics of Vienna or the Binnengasthuis in Amsterdam. These were overwhelmingly the results of puerperal sepsis, caused by examinations of labouring mothers by medical doctors and students without gloves or washing hands between examinations, at a time when medical science did not recognise the role of micro-organisms. In 1847 Semmelweis was able to show the danger of unhygienic procedures. His studies were ignored for almost half a century⁵ by the medical establishment until

1881. After his recommendations to adhere to strict hygiene measures were followed in the labour wards the MMR fell dramatically.

Of course we all know that there are very many reasons for countries to have high MMRs and therefore this problem has to be tackled on many fronts.

For clinicians and consultants at the level of a central hospital the front should be clear. We have to deal with mothers who come to seek help very late in their pregnancy at a time when the delivery has changed into a struggle for pure survival of the mother. Under those very urgent and difficult circumstances we need to be well prepared and well equipped to deal with emergencies. Especially is this so in a situation where everything else seems to be in disarray due to poor facilities. We cannot afford to be understaffed and under-equipped and thus ill prepared.

Those who cannot see that curative services are essential in the fight against maternal deaths and feel that only primary health care (PHC) should be the priority, do not understand that preventive and curative services have to work hand in hand. They are, in fact, two sides of the same coin.⁶

With an MMR such as ours, who can still have a good night's sleep after a day in any health facility in Malawi? How can we live in the knowledge that our women are dying from entirely preventable causes in 2005 at a scale that has not been seen in Europe since medieval times? We repeat: Medieval times!!

Technologically Malawi has advanced in some areas to compare with the more developed countries. We have cell phones, TV screens, latest brands of cars, refrigerators and computers readily available at a price right here. Yet when it comes to preventing mothers from dying unnecessarily we are in the dark ages!

Why is this? What can we clinicians do about it? Is there really nothing we can do?

Some physicians feel that they should just do their work and do it well and then things will improve. History has proven this to be wrong.⁷ Others feel they should actively seek to improve the fate of their patients beyond the pure clinical situation and become advocates for them.⁸ There is a growing sense that MMR's such as ours are little else than a symptom of a massive human rights infringement.⁹

This is probably part of the answer to the painful 'why'. Why are our women still living in the dark ages while much of the rest of the world has arrived in the 21st Century? It is because they are poor, very poor¹⁰, voiceless and, and we

should never forget that, also because they are female! As a result of this they do not have the power to actually have their (human) rights secured, first of which is the right to, not only health, but life itself.¹¹ Because this is so, we, the clinicians caring for them have to try to work and fight, if need be, for their rights! And to do so with passion, with feeling and care!

We must not allow our well developed skill of reasoning and balanced judgement to blind our hearts from the tragedy of needless deaths of our mothers as it is unfolding in front of our very eyes.

In the context of maternal mortality of this magnitude the first aim has to be to get our respective clinical settings right, to actually be in a physical position to indeed provide emergency obstetric care. This is not even the case in all central hospitals in our country! Why not? Because we do not have the (financial) power to get it done! Does it have to end here?

Our answer is a very clear: NO! No, it should not end here, we Obstetricians have an obligation too, to cry out as advocates in order that the rights and lives of our patients are recognised, honoured and ultimately saved.¹²

We have to be advocates for our patients, especially since our patients are traditionally, economically and more importantly politically weak.¹³ Those of our many colleagues who are trying to support the fight against an ever rising maternal mortality in Malawi from within the various ministries and sub-units, need this advocacy from us. It is through us that they will be in touch with reality and through this information they will be able to fight from their political platform for improvement. They are our partners! We need them and they need us!

We have to make sure that the history of Semmelweis does not repeat itself. That we do not need to wait another century before all the knowledge we have to prevent maternal deaths will be implemented!

We have to fight together against this incredible scandal, which is contrary to Section 13(c) of the Constitution of Malawi¹⁴, and bring our patients who are our sisters, wives, daughters, colleagues, friends, neighbours and mothers back from the remote past into today!

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