Maternal and newborn health in Malawi

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Introduction

Malawi has one of the poorest indicators of health in developing countries. The maternal mortality ratio is one of the highest in Africa. It almost doubled by 80% from 620/ 100 000 to 1120/ 100 000 live births in 2000 and the fertility rate is also high at 6.3 children per woman (National Statistical Office and ORC Macro 2001). Currently the maternal mortality ratio has dropped to 984/ 100 000 live births while the fertility rate is at 6 children according to the Malawi Demographic Survey of 2004 (National Statistical Office 2005). The neonatal mortality was equally high at 42/ 1000 live births though it has decreased to 27/ 1000 (National Statistical Office and ORC Macro, 2005).

The direct causes of maternal mortality in Malawi include complications of abortions (18%), obstructed labour/ ruptured uterus (20%), haemorrhage (24%), sepsis (24%) and eclampsia (4%) (Malawi Safe Motherhood Project and Ministry of Health and Population, 2004). Prevention of maternal deaths is closely linked to women's timely utilization of emergency obstetric care when complications arise. Women's inability to access care has been related to three delays. Delay in deciding to seek medical care, reaching a health facility and receiving medical care at the health facility (Maine, McCarthy and Ward, 1993). A combination of two or all three delays is usually responsible for a maternal death (Castro, Campero, Hemandez and Langer, 2000)

It is imperative for government to work towards having skilled attendance at birth and emergency obstetric care available as global evidence indicates that these are key to reduction of maternal mortality (Ministry of Health, 2005).

Improving Newborn Health In Malawi

When babies do not survive but die it results in women attempting to have more children with the hope that some of them will grow to adulthood leading to too many pregnancies. "Historically, families have tended not to limit their fertility until infant mortality begins to decline and they are more confident that their children will survive" (Yinger and Ransom, 2003 p. 3).

Women whose babies die want to become pregnant almost immediately therefore, most will not utilize family planning services at this time. This will lead to maternal ill health, as the mothers do not rest adequately to replenish their reserves. Poor maternal health negatively impacts on neonatal outcomes by increasing premature births and low birth-weight babies.

The greatest risk of newborn babies dying is soon after birth. Almost two-thirds of deaths occur in the first month of life; among these, more than two-thirds die in their first week and of those who die in the first week, two-thirds die in the first 24 hours of life (Beck, Ganges, Goldman and Long, 2003). Yet there are no programmes in place to monitor babies until at one week and six weeks respectively when mothers are advised to come for postnatal check ups. This is past the critical period when the babies are most likely to die. Programmes to reduce child mortality have proven to be effective but they focus on children more than one month old (Yinger and Ransom, 2003). In Malawi these programmes start mostly from six weeks at under five clinics. Seeing babies earlier on third or fourth day after delivery would promote early identification and timely management of complications. Involvement of communities is important to ensure that all women who deliver at home and with Traditional Birth Attendants (TBAs) will go to health facilities where both the mothers and babies will be assessed for presence of any deviations and complications. This is significant because assistance by a skilled attendant at birth is only 57% (National Statistical Office and ORC Macro, 2005).

Darmstadt et. al (2005) identified 16 interventions for low to middle income countries that were combined into three delivery modes: outreach, family- community and facility based clinical care. The first two modes address neonatal care at community level for home births and where it is difficult to access neonatal care. It involves follow up of low birth weight babies, management of pneumonia with oral antibiotics with accessible emergency neonatal care for ill newborn babies at a health facility.

Approach To Improve And Promote Quality Maternal Health Care

Every woman of reproductive age should have access to family planning services. Utilization of family planning methods reduces maternal mortality by 20- 35% (UNFPA, 2005). This is because unwanted pregnancies and unsafe abortions are reduced.

Every pregnant woman should have access to focused antenatal care and clean and safe delivery by a skilled attendant. Every pregnant woman who develops complications should have access to emergency obstetric care. This does not necessarily mean that all 6 signal functions should be provided at each maternity, but the skilled attendant should be able to diagnose the complication and provide obstetric first aid prior to referral to an emergency obstetric care (EmOC) center. This means that a first level health facility that is closest to any community should be able to provide basic emergency obstetric care before referral to the next level. If the skilled attendant is not able to manage the complication at the first level health facility, then she should have quick access to a functioning referral system (transport & communication) to the nearest EmOC facility. This is necessary as it is impossible to predict which women will develop complications (Vanneste, Ronsmans, Chakraborty and deFrancisco, 2000). Women with complications have to reach a health facility with emergency obstetric care quickly. Maternal deaths were strongly associated with increased distance, 6-25 km compared to 0- 5 km from a hospital in a

study done in rural Guinea Bissau (Paxton, Maine, Freedman, Fry, and Lobis, 2005).

In order to save women's lives during childbirth it is imperative that these women are treated quickly and appropriately when they reach a health facility with emergency obstetric care. The urgency of different complications from onset to death without treatment varies. The shortest average time is two hours for postpartum haemorrhage (Hofman, 2004). A timely met need for emergency obstetric care is associated with a reduction in maternal mortality. Sri Lanka, a developing country with the lowest maternal mortality ratio has the highest met need while countries such as Mozambique and Nepal with a low met need (R = 0.64) have the highest maternal mortality ratio (Paxton, Maine, Freedman, Fry and Lobis, 2005).

Conclusion

This article has looked at maternal and newborn health in Malawi and suggested approaches to promote quality maternal and newborn health care. It has acknowledged the prevalence and extent of the problem, as well as looking at possible local solutions.

References

1. Beck, D., Ganges, F., Goldman, S. and Long, P. (2004) Care of the Newborn Reference Manual. Washing: Kinetik
2. Castro, R., Campero, L., Hemandez, B. and Langer, A. (2000) A study on maternal
3. mortality in Mexico through a qualitative approach. Journal of Women's Health and Gender Based Medicine, 9 (6), 679- 691
4. Darmstadt, G.L., Bhutta, Z.A., Cousens, S., Adam, T., Walker, N. and Benis,.L. (2005)
5. Neonatal Survival 2: Evidence- based, cost effective interventions: how many newborn babies can we save? The Lancet, 365, 977-988
6. DFID (2005) Developing a Human Rights- Based Approach to Addressing Maternal Mortality. Website: www.dfid.gov.uk/pubs/files/maternal-desk.pdf
7. Hofman, J.J. (2004). Maternal mortality: definition and determinants. Unpublished paper presented at an obstetric seminar on making pregnancy safer for doctors, clinical officers and midwives at College of Medicine, 24-25 July 2004.
8. Maine, D., McCarthy, J and Ward, V.M. (1993). Guidelines for monitoring progress in reduction of maternal mortality (A work in progress). UNICEF
9. Malawi Safe Motherhood Programme, Malawi Safe Motherhood Project and Ministry of Health and Population. (2000). Obstetric life skills training manual for Malawi. Limbe: Montfort Press.
10. Ministry of Health (2005) Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi. Lilongwe: Malawi.
11. National Statistical Office and ORC Macro. (2001). Malawi Demographic and HealthSurvey 2000. Zomba: Malawi and Claverton: Maryland, USA.
12. National Statistical Office and ORC Macro. (2005). Malawi Demographic and Health Survey 2004. Zomba: Malawi and Claverton: Maryland, USA.
13. Paxton, A., Maine, D., Freedman, L., Fry, D. and Lobis, S. (2005). The evidence for emergency obstetric care. International Journal of Gynecology and Obstetrics, 88, 181- 193
14. UNFPA (2005) State of World Population 2005: The Promise of Equality. New York: United Nations Population Fund.
15. Vanneste, A. Ronsmans, C., Chakraborty J., and de Francisco, A. (2000). `Prenatal screening in rural Bangladesh: from prediction to care. Retieved 23/08 2005, from Health Policy Plan 2000. 15: 1- 10 Website: www.elsevier.com/locate/ ijgo
16. Yinger, N.V. and Ransom E.I. (2003) Why Invest in Newborn Health? Save the Children: Population Reference Bureau