



A NEW DEAL FOR MOTHERS IN DEVELOPING COUNTRIES

❖ PREAMBLE

This paper considers, the Human Person, Solidarity, Subsidiarity and the Common Good in order to discuss the dignity, the state of health, and the human rights of both mothers and of those who care for them, especially obstetricians. Mothers everywhere are among the poorest of the poor both in body and spirit when hundreds of thousands die or suffer injuries giving birth to new life as a consequence of neglect in poor countries, or when millions of mothers in rich countries, often alone and in despair, are pressured into destroying their unborn children. The paper suggests what needs to be done obstetrically in the name of social justice and human solidarity to deal with this enormous amount of suffering and also suggests a new funding initiative.

❖ THE HUMAN PERSON

A basic principle is that each individual possesses the inherent dignity of a human person, who is not just “something.” He or she is “someone,” capable of both self-knowledge and self-possession. Human life is, therefore, sacred, and it is the starting point of a moral vision for society. Furthermore, human beings are meant to live together freely, giving of themselves and entering into communion with other persons. Thus an emphasis must be placed on the inalienable rights of every person: the right to life; to marry and found a family; to practice a religion; to work; and to associate. These rights are required for human flourishing, and they require, clothing, shelter, employment, health care and education.

• The Dignity of Motherhood

Motherhood has special significance in most cultures, especially in developing countries, because motherhood is the most complete expression of the special vocation of women. Motherhood as a gift to humanity is of such fundamental importance that it must be cherished and served in a special way, especially in our times.

❖ SOLIDARITY (Option for the Poor and Vulnerable)

“Solidarity... is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say, to the good of all and of each individual, because we are all really responsible for all.” (Pope John Paul II, *Sollicitudo Rei Socialis* 38.)

The way to a healthy society is through healthy families, and mothers are the key to families. After reviewing current maternal mortality ratios and morbidity rates in developing countries, the only conclusion that any reasonable person must arrive at is that our world cares very little for mothers and, for that matter, for their unborn children.

• The State of Health of Motherhood.

It is estimated that, world-wide, there are 200 million women pregnant each year but of these United Nations (UN), international family planning and population agencies stating have estimated that 30 to 50 million pregnancies are aborted and there are close to 600,000 maternal deaths of which 68,000 are caused by what is termed “unsafe” abortion. However, these figures are “guesstimates” based on poor data. A more accurate study reported in the Lancet Medical Journal in June 2010, put the number of deaths at 330,000. When comparing the rich and poor countries of the world, the risk of dying during pregnancy is stark. For example, in Canada the ratio of maternal deaths to the number of pregnancies is 1:7,300, whereas in some African countries it is 1:7. No other development indicators show such disparity between rich and poor countries, and, what is more, the gap is not closing. Thus, death during pregnancy is the leading cause of death among women in the childbearing age group, and, moreover, the World Health Organisation has stated that it is the most serious of world health problems.

Most maternal deaths occur in the small manyattas (huts) in villages. They occur in the last trimester, during childbirth or in the first week following delivery. These mothers often die alone in terror, 25% of them from haemorrhage; 12% suffering the agony of infection; 8% as a result of obstructed labour, often because they are young, and their pelvises are too small; 12% from hypertension; 12% from malaria, HIV, or severe anaemia; and 13% as a result of complications arising from septic abortion either both spontaneous and induced. Most deaths occur in the last 3 months of pregnancy or during the first week following delivery and 85% of these causes may be anticipated or identified early and prevented. Not only are the lives of these women abruptly ended, but so are those

of their newborn babies. Moreover, the chances of the survival of their already born young children decrease dramatically.

Unfortunately, these deaths are only the tip of the iceberg. It is estimated that for every death, 30 more suffer long-term damage to their health, for example, from obstetric fistulae. Fistulae occur most frequently as a consequence of neglected obstructed labour (insufficient room for the baby to pass through the maternal pelvis) which could be avoided by caesarean section. The result is injury to the bladder and rectum, with resulting incontinence of urine and/or faeces. As a consequence, these women become outcasts and are treated as lepers by husbands, families, and communities, simply because they are wet and offensive. They suffer pain, humiliation, and lifelong debility, if not treated. World-wide estimates are that two million young and forgotten women are living with the problem mostly in sub-Saharan Africa.

These deaths and injuries are readily preventable by ensuring access to essential obstetrical care. Furthermore, fistulae are treatable with specialised surgery and nursing care, but at present, there are insufficient trained doctors, nurses or specialised hospitals to provide the necessary care and not enough is being done to address this tragedy which amounts to culpable neglect.

- **Violence against the Unborn and Women**

Violence to women may be done by *Commission*, for example, by abortion, genital mutilation, and sexual assault, especially during times of war, or by trafficking, or domestic abuse, all of which have received considerable attention by civil societies. Violence, however, may also be perpetrated by *omission* as in the case of neglect during pregnancy and childbirth.

- **The Option for the Poor and Vulnerable**

The poor, of which mothers and babies are, inarguably, the most vulnerable, have the most urgent claim on the consciences of national governments and the world. This option for the poor considers the policies or lack thereof, by governments and by private and public institutions, and their efforts to meet the right to health care of the most marginalised.

- **The Call to Solidarity with the Unborn Child**

The most fundamental principle of all is the sanctity of human life. The human person has inherent dignity from conception to natural death. It follows logically, then, that to exercise all personal rights, including the right to health care, depends on being born alive. In *Christifidelis Laici*, the late Holy Father, John Paul II, wrote the following:

“Above all, the common outcry, which is justly made on behalf of the human rights – for example, the right to health, to home, to work, to family, to culture – is false and illusory if the right to life, the most basic and fundamental right and the condition for all other personal rights, is not defended with maximum determination.”

- **The Call to Solidarity with the Mother**

Maternal deaths and birth injuries, such as obstetric fistulae, are among the greatest tragedies of our times, especially since they are preventable and treatable. Tragically, however, there are not the trained personnel or hospitals needed, especially for the rural poor. The problems of maternal health and the necessity for improvement of maternal care provided have been discussed many times since the 1987 *UN Safe Motherhood Conference* in Nairobi, which first drew attention to this tragedy. The “call to action” was made again as the fifth *UN Millennium Development Goal* (MDG), to reduce the maternal mortality ratio by 75% by the year 2015. Most recently maternal health was again made the focus of the international community when it was put on the agenda of the G20 summit in June 2010.

- **Health Care as a Human Right**

The preamble of the *Universal Declaration of Human Rights* states that, “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” Article 25 states the following:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care, necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance.”

The consensus of the obstetrical community is that the solution to reducing maternal and perinatal mortalities and morbidities as well as stillbirths is contingent on providing prenatal care, skilled attendants at all deliveries, and accessibility to specialist care for life threatening complications. Nonetheless, driven by ideology, most international health aid agencies continue to insist that the principle strategy to reducing maternal deaths in developing countries should be the promotion of so called “safe” abortion and birth control, despite no sound reasoning or evidence for

community support for such policies. While billions of dollars have been spent on such “reproductive health programmes,” more is demanded. Moreover, only a small fraction of the billions spent is allocated to the provision of essential obstetrical services that would ensure mothers and their babies survive pregnancy and childbirth. The former Director General of the World Health Organisation (WHO), Dr. Halfdan Mahler, commented at the **1987 Safe Motherhood Conference** that;

“We know enough to act now, it could be done; it ought to be done; and in the name of social justice and human solidarity, it must be done.”

Common sense would dictate that most mothers, including those in Africa, do not want to abort their babies, particularly knowing that they are the future of their families, communities, and countries. Certainly, no mother expects, or should expect, to die or suffer birth injuries as a result of pregnancy. Unlike their sisters in developed nations, mothers in developing countries, already marginalised by poverty, have no power or voice to overcome the lack of adequate care and those who die obviously have no voice only ours. The world community is morally obliged therefore, to plead their case for adequate care, care of the sort mothers in the rich world have and take for granted.

❖ **SUBSIDIARITY**

“It is a fundamental principle of social philosophy, fixed and unchangeable, that one should not draw from individuals and commit to the community what they can accomplish by their own enterprise and industry.” (Pope Pius XI, *Quadragesimo Anno*, 79)

The present world view of the value of motherhood and the amount of suffering that so many mothers endure requires the international community to respond in the same unprecedented manner that it did when the seriousness of the Aids pandemic was realised in 1981. Similarly, the approach must be not only acceptable to communities but to individuals. It must also be innovative, affordable, and sustainable.

- **A Model of Comprehensive Rural Maternity Care in Developing Countries**

MaterCare International (MCI) has developed a model of comprehensive obstetrical care for rural areas, which takes maternal health services closer to village communities. The model not only concerns the obstetrical causes of death but also takes into consideration the circumstances that increases the risk of dying e.g. lack of transport; lack of communication to seek professional help; poor environmental conditions e.g. severe drought; poor infrastructure e.g. roads, clinics, hospitals; difficult social circumstances leading to obstructed decision making such that women cannot seek hospital care without the man’s permission.

MCI works through bishops, in dioceses and parishes as the Catholic Church provides 30 to 40 % of health care to rural populations, particularly in Africa. MCI works with local medical colleagues and encourages women’s, and community groups (tribal elders and traditional birth attendants) to be involved. The model provides a comprehensive approach to the delivery of maternity care. It is based around a small base hospital unit (20 beds) which provides prenatal care, treatment for common medical conditions such as malaria, HIV, and severe anaemia, immunization against tetanus, and specialist management of life threatening obstetrical complications with caesarean sections and blood transfusions. Some of these essential services, found usually only in hospitals, are made more accessible to the mother in rural clinics, staffed by trained midwives who provide care throughout pregnancy for normal cases and early referral to the hospital of mothers with complications. The hospital and clinics are linked by radio or cell phone to an emergency transport which can go to the mother with life threatening complications. The emergency transport is fully equipped and staffed to resuscitate and transfer the mother to the hospital in a safe and timely manner.

Maternity waiting homes (traditional manyattas) are provided within the hospital or clinic compounds where mothers with complications or uncomplicated pregnancy from remote areas, may wait for delivery but may also take care of themselves or by a relative. Training programmes in high-risk obstetrics are provided for doctors and midwives. Appropriate training for traditional birth attendants in the villages, to recognise and refer high-risk mothers to the hospital or clinic are also provided. Alternative energy sources are used for heating water and rainwater is collected for the laundry and cleaning. Only essential drugs are administered. Simple transportation (motorbike ambulances) are being introduced for use between clinics and villages. Finally, trained natural family planning personnel will be available in the maternity unit.

Nothing suggested here is new as many of the interventions are used individually. What is innovative is to put them all together to address the various contributing factors that lead to maternal and infant deaths. The model was developed as a demonstration project in a dioceses in Nigeria in the early 1990’s and later refined in a diocese in Ghana in the early 2000’s. The results of its introduction have shown increased referrals of high-risk mothers to the hospital from which it can be reasonably inferred that maternal deaths and birth injuries have been reduced. Presently the same model is being introduced into the Apostolic Vicariate of Isiolo, Kenya, a large rural district with a nomadic population, with poor or non-existent roads, and a non-existent health care infrastructure.

Of basic importance to countering the culture of death must be the evangelisation of health professionals, especially obstetricians, gynaecologists and midwives. The Church has set the ethical and moral limits within which they may act, for example in the areas of fertility regulation and treatments. They must work to promote natural fertility awareness methods and to increase understanding of the unacceptability of the contraceptive mentality and reproductive technologies that manipulate new life.

THE COMMON GOOD

The Vatican II document *Gaudium et Spes* offers this definition of the common good;

“...the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfilment, today takes on an increasingly universal complexion and consequently involves rights and duties with respect to the whole human race. Every social group must take account of the needs and legitimate aspirations of other groups, and even of the general welfare of the entire human family.” (#26)

- **The Cost**

During the last two years, the world has experienced an economic crisis almost as great as the depression of the 1920's and 30's. Although many in rich countries have suffered the loss of jobs and pensions, most have been greatly blessed to live in countries with abundant resources and have been protected from the extreme consequences of the crisis. However, women in developing countries and their children, both unborn and born, who have contributed the least to the economic crisis, have been the least able to defend themselves against its devastating impact of lack of basics, food, water, and health care. The UN's plea is that the needs of the world's poor be given priority, but many of the rich G8 countries have reneged on their aid pledges while their collective military spending has surged to a new high of 1.4 trillion dollars US in 2008. Moreover, they have spent 8.7 trillion dollars US on bailing out banks. The result has been that aid to developing countries has been cutback to the point that health systems that were already weak are now increasingly unable to care for their most vulnerable.

Of the eight MDGs, the UN and the international health community admit that the fifth, which concerns improvement of maternal health care, is the most neglected. A report in the July 2007 issue of the *British Medical Journal* states that “At the present rate of progress the fifth MDG, will not be met for 275 years, that is, 2282, and not in 2015 as intended. The responsibility for this failure lies with governments, the international community, and health professionals for their lack of compassion, political will, imagination, and a conspiracy of silence. In addition, there has been a diversion of resources, the promotion of abortion and birth control under the aegis of programmes to reduce maternal mortality. It is egregious to suggest to African mothers that their lives and health will be improved by killing their babies. The root causes of all this suffering will not be solved by more death and despair.

It is estimated that to meet the MDGs, \$35 per head must be spent on a range of essential health services. The present average spending on health in developing countries is approximately \$15 per head. To meet these goals, the poorest countries of the world must find an extra 40 to 100 billion dollars US. Nevertheless, these sums pale into insignificance when compared to the spending by rich countries on armaments and the bailing out of banks. The world cannot continue to ignore the plight of the poorest of the poor (mothers and babies). However, things changed in 2010 when the government of Canada, which held the presidency of the G8 /G20 countries, announced that the international focus of funding was to be on the provision of maternal care without abortion. This is a first for any rich world government which is not only pro-life but also have a three-fold return on investment, a decrease in the deaths of maternal and perinatal deaths and also stillbirths. The Canadian Prime Minister and the President of Tanzania have since been appointed as co-chairs of the UN oversight commission to ensure that the funds promised are forthcoming.

- **The Church and Maternal Health Care and the Problem for Catholic Inspired NGO's**

During the last 30 years the world has accepted that maternal health care should be based on providing reproductive health services (abortion and birth control). On the other hand, the Roman Catholic Church has a long history of providing maternity care that is based on the principle of the sanctity of life. Tragically, however, the Church's continuation in that ministry is far from assured due both to internal dissent and to external attack by governments and international health and population agencies. Many of the latter actually regard the teaching of the Church as irrelevant precisely because of its insistence on the dignity of all human life, of procreation, and of motherhood and work to have Church and faith based NGOs removed from maternal health care altogether. In practice this is being achieved by government and private funding agencies discriminating against Catholic NGOs and by legislation, which removes the right of doctors and midwives to practice according to their consciences and restricting Catholic hospitals from providing services based on faith beliefs.

The questions are what effect does all this have on women and mothers? Where will they obtain opinions and treatment for their health needs, which respect their faith and moral convictions? Are women being unduly influenced

by doctors or nurses who do not understand or care about religious convictions? In other words, who in the future will make any practical reality of the right to life of the unborn, the religious beliefs of mothers and those of their care givers? Who will respond to the late Holy Father's challenge to improve the quality of health care for mothers and infants, especially for the poor? The Catholic Church has a long history of delivery of maternal health care and has established maternity hospitals which were developed into the finest in the world. This tradition is no longer assured.

❖ **A “MARSHALL PLAN” - A NEW DEAL FOR MOTHERS**

The Marshall Plan was developed in 1947 to respond to the devastation of Europe following World War II and in response to the threat posed by the tyranny of Soviet communism to Western civilisation. In this 21st Century world, especially in much of Africa, maternal health is in a disastrous state. Traditional family and marriage, are constantly threatened by a culture of death and as the Holy Father commented in his homily during the opening Mass of the 2009 Synod for Africa;

‘There is absolutely no doubt that the so-called "First World" has exported up to now and continues to export its spiritual toxic waste that contaminates the peoples of other continents, particularly those of Africa.’

Most Church-related health care programmes in African countries do not receive any government funding even though they provide approximately 40% of beds, especially in rural areas. Thus, there is immense pressure on developing countries to accept the policies of the UN and G8 countries aid agencies and anti-life international organisations. The Church has no option but to protest but that is not enough.

There must be an innovative, proactive, and courageous response. Despite the fact that some may think that to develop a sort of emergency fund or “Marshall plan” for mothers is unrealistic, mothers and their children everywhere have every right, a right based on life and hope, to have the care they so desperately need. Contributions to the cost of this care could come from developing countries themselves, Catholic foundations, mission agencies, fraternal service organisations; and individual donors from around the world. To set up such a plan would require unprecedented cooperation between Catholic-inspired NGOs, but responding to the dire crisis in maternal health care actually provides the Church with a golden opportunity to show that it still truly cares in practice and that the Church is still relevant to the needs of poor mothers, and that, indeed, it will continue to provide the same excellent, caring service that it has always provided.

Throughout its history, no matter the health crisis, the Church has always responded, be it the plague, smallpox, or leprosy, and so on. In recent times, the international community, the Church and its agencies joined in an unprecedented response to the AIDS pandemic. Currently, given the evident failure to do so as yet, a similar urgent response to the needs of mothers is needed if the 5th MDG is to be met. It is a matter of justice.

❖ **CONCLUSION**

St Luke tells us of the incident of the women who raised her voice in the crowd and said to Jesus, **“Blessed is the womb that bore you and the breasts that nursed you”**. In reply Jesus said **“Blessed rather are those who hear the word and keep it” (Luke 11. 27-28)**. Jesus’ answer was not one of disapproval of what the women had said about His Mother, as he understood more than anyone that Mary, was the complete mother, who gave Him total and unconditional love and shared intimately in His life and later intimately in His death. Jesus was, however, issuing a call to action to His Church to follow His Mother’s example of love and service which is so necessary in these difficult times.

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