BORN TO DIE

TODAY IS WORLD POVERTY DAY. ERADICATING DESTITUTION GLOBALLY BEGINS WITH A FOCUS ON MATERNAL HEALTH AND PUTTING WOMEN'S PHYSICAL ISSUES FIRST IN THE DEVELOPING WORLD. **ROBIN REBEIRO** REPORTS THAT MATERNAL DEATH IS THE HEALTH STATISTIC WITH THE GREATEST DISPARITY BETWEEN DEVELOPED AND DEVELOPING COUNTRIES.

For every young mother who dies in childbirth, an infant is left motherless, or fighting for its own life. An estimated US$1 billion are lost per year as a result of maternal and newborn deaths.

Tackling the problem of maternal death is an essential step towards the eradication of poverty.

During the United Nations Millennium Summit in 2000, 189 world leaders signed the UN Millennium Declaration, a promise to commit to the goals of the epic End Poverty 2015 campaign. Its directives aim to significantly reduce extreme poverty in the developing world by setting out a series of time-bound targets, the Millennium Development Goals, of which there are eight.

Many of them overlap in significance, making it impossible to achieve one without the other, especially that of Promoting Gender Equality and Empowering Women without Improving Maternal Health.

The UN Population Fund estimates that of the 500,000 women who die during pregnancy, or childbirth, 90 per cent are in Africa and Asia. The thing is, the majority die from preventable causes, such as severe bleeding, infections, eclampsia and obstructed labour. Several factors contribute to the inappropriately high maternal mortality rates in the developing world, all of which require the utmost attention both at public and political levels. Almost all these factors represent a lack of concern with women in the developing world and contribute to the continuity of extreme poverty.

Among them is a lack of access to education and sexual health promotion. In most of the developing world, women's health promotion is not a priority, and other necessities, such as the need to earn an income and care for the family, are highlighted instead. Family and cultural commitments mean most women in the developing world have had hardly any access to education. Along with basic life skills, such as reading and writing, many young women have not had the opportunity to learn about sexual and reproductive health, how to prevent unwanted [and potentially fatal] sexually transmitted diseases and pregnancies.

Cultural practices are another issue. It is a known fact that child marriage is still practised in several countries. Many young women are forced by their families into marriage at a very young age – and many have not yet even developed fully in a reproductive sense. Girls as young as 12 are giving birth to their first of many children.

The World Health Organisation and UNFPA both list obstetric fistula as a common condition among impoverished young women, especially those giving birth in their early teens. Defined as a hole in the vagina, or rectum, caused by labour that is prolonged – often for days – without treatment, it usually leads to the death of the baby.

Because the fistula leaves women leaking urine, or faeces, or both, it typically results in social isolation, depression and deepening poverty.

Left untreated, the fistula can also lead to chronic medical problems.

In the developing world, many communities are isolated from access to basic medical care, including pre- and post-partum. Shortages of doctors, midwives and basic life-saving medical equipment mean these are often out of reach for many women in their maternal phase. As a result, they remain unaware of how to care for their reproductive health and that of their unborn children and have no way of receiving medical guidance.

The WHO Department of Reproductive Health and Research reports that maternal death is the health statistic with the greatest disparity between developed and developing countries. Ensuring universal access to skilled attendance at childbirth, emergency obstetric care, post-partum care and widening contraceptive choices are vital interventions, which have shown a reduction in maternal mortality and morbidity.

The empowerment of women begins with education – not only in health – allowing them to contribute to the socio-economic development of their countries. Sexual health education is relevant for a woman to know her rights; to know her body; and to protect herself from ill health and death. Women of all backgrounds must also be informed of ways to avoid violence, abuse and other inhibiting factors that prevent them from playing a role in society.

Knowledge is power. Even here in Malta, sexual and reproductive health is essential for the empowerment of every individual. The WHO acknowledges the achievement of sexual and reproductive health as a human rights issue. Everyone has a right to information on how to protect themselves from harm.

SAVING BABIES

WHEN **HELEN RAINE**'S SON WAS BORN, HE WAS ADMITTED TO THE HOSPITAL'S INTENSIVE CARE UNIT FOR BABIES. FORTUNATELY, NOT EVERY NEWBORN GETS TO VISIT, BUT IF THEY DO, THEY ARE IN GOOD HANDS. HER OWN POSITIVE EXPERIENCE HIGHLIGHTS THE CONTRAST BETWEEN DEVELOPED AND DEVELOPING COUNTRIES AND THE LACK OF ACCESS TO BASIC MEDICAL CARE IN THE LATTER.

Tucked away at the back of Mater Dei Hospital, along a corridor adjoining the maternity wards, is a special unit – the Neonatal and Pediatrics Intensive Care Unit. Most expectant parents have their babies at the hospital without ever being aware of its existence. But for some newborns, the NPICU becomes home for a while and their parents spend many hours there.

So what happens when a baby is admitted to the extraordinary unit and into the care of its specialised staff? It starts with a simple buzzer. The door to the unit has to be opened by the staff inside, and then you follow a long corridor down to the nurses' station. A series of little wards leads off this central station, and parents arriving for the first time are guided by staff to their baby.

There is no doubt that seeing a sick baby for the first time after birth is a traumatic experience for any parent. Most of them are premature, or required some sort of surgery, or specialist care immediately after birth. The very nature of intensive care means that the child looks highly medicalised – each one is hooked up to monitors; many have intravenous drips; some need oxygen and feeding tubes. Alarms go off continuously as the monitors alert the nurses to any change in the child's condition. It is a serious shock to see your tiny baby like this, and it inevitably provokes a violent emotional response from parents who have imagined holding, kissing and feeding their child as soon as it is born. Instead, in the NPICU, the child is often out of reach, inside an incubator and usually looking incredibly fragile and sick. It is everything you fear in pregnancy come to stark reality.

This is where the commitment of every staff member in the unit first makes itself felt. From the courteous security guard at the nurses' station, who greets parents with a smile, to the cheerful and efficient nurses, the genuine care in the unit is immediately obvious. Nurses take the time to explain the child's situation, how the monitoring is working, what the many numbers flashing on the screens mean. They answer endless questions [often the same ones repeated over and over again because it's too much to take in at first] with patience, understanding and humour. They explain to parents how to tell the difference between a serious alarm that needs immediate attention and an "alert" alarm that can be ignored for longer. Initially, every sound sends an already overwrought parent into a frenzy, so understanding what each one means is essential for sanity.

Nurse Sandra Agius has worked in the unit for 19 years and agrees there is something special about its team and the way the staff has managed to create such a positive atmosphere, which translates into great quality treatment and, more importantly, an overall caring environment. "The best thing about working in the NPICU is getting the chance to care for babies, and even better, seeing them go home," says Sandra.

But with the highs can also come real lows. "For me, the worst part of the job is, of course, when a baby dies." Teamwork is again important, and the staff supports each other and the parents through the grief of the loss.

When the surgeons and doctors think a child may have a serious complication, the parents are as big a concern as the patient. A separate interview room gives doctors the space to speak to worried parents – and they do take the time to do this. It cannot be overstated how important it is for parents to have the doctors take the time out of their schedule to explain the treatment needed for the child, and involve the parents in the decision-making process. This diffuses a large amount of their stress and uncertainty, making operations and procedures easier to cope with.

The bottom line is that the NPICU is about saving babies. The unit has about 350 admissions a year and **the staff has saved infants after just 23 weeks in the womb.** They also cope regularly with multiple births and have performed complex life-saving surgery on tiny bodies. But more than that, the NPICU is about making sure that families go home intact and that parents cope with the trauma of a sick, or premature child. Achieving that goal takes much more than medical knowledge and surgical skill. It takes heart, and this the NPICU staff have in abundance. ■