

## Maternity Care Elsewhere

*Imagine* a country where you have a 1% chance of dying in childbirth from haemorrhage because there is no blood or suitable oxytocics available, from eclampsia because there may be no appropriate management protocol, from sepsis because the supply of suitable antibiotics has run out, from perforated bowel because someone has tried to abort your pregnancy using a sharpened knitting needle or straightened coat hanger.

You may also die because you have been in obstructed labour for four days and need a caesarean section but you have no money and the surgeon refuses to operate without payment in advance. Delivery by forceps or Ventouse is almost never done but if you have a caesarean, a midline incision is routine rather than a less painful Pfannenstiel. There will be no post-operative recovery area for you to be monitored and given oxygen until you are awake, made pain free and given anti-emetics if necessary after ether anaesthesia. You will be sent back, barely awake; to a poorly staffed ward where you will be given inadequate or no post-operative analgesia. You will suffer in silence because that is your lot in life as a poor African woman.

The midwives and doctors are overworked, underpaid and generally feel undervalued and exhausted most of the time. Senior obstetric backup is rarely available because either the specialists are working in private practice or else cannot be bothered to come when asked. The rationale may be that a death in your hands is not good for your private practice, so as long as you do not 'put the gloves on' it is not your fault. Whereas in Western countries if a senior does not attend when requested by a more junior colleague it can be a significant issue.

You have travelled for many hours to reach the hospital but when you arrive you may be kept waiting for hours. You may then be examined with surgical gloves, which have already been used in other women. You will not be allowed to eat or drink. You will be given no pain relief. You will only be delivered in the lithotomy position. The only toilet area may be under a tree in the hospital grounds. Or you may be one of a group of twenty women at the main teaching hospital in the capital city lying in a corridor in various states of distress and undress waiting for your turn to be delivered on a trolley with absolutely no privacy, by one of a group of four (? unsupervised) white coated male medical students. You may survive but your baby has a 40% chance of dying. The equipment and the training of staff in resuscitation of the newborn may be woefully inadequate. If you have been in obstructed labour for four or five days your unborn baby will probably have died but in the meantime its head, impacted for too long in your pelvis, may have caused necrosis of part of the bladder and you develop a vesico-vaginal fistula (VVF) and you will then leak urine continuously for the rest of your life unless the hole is repaired. You will smell and become socially isolated from your friends and family in spite of only being a teenager. You will be unable to use public transport or gain employment. As a result of all these problems you may decide suicide is the best option.

*Welcome* to Uganda in 2008, and sadly to other countries in sub-Saharan Africa where the idea of achieving 'Millennium Development Goal' number five' – to decrease maternal mortality between 1995 and 2015 by 75%' is totally unrealistic.

**What can one do to help?** I can't really answer that question but I will try. With generous support from the Basingstoke and North Hampshire Hospitals Trust I took a team of nine medical staff, which included four midwives, two obstetricians, two obstetric anaesthetists and one neonatologist to Uganda for 11 days. We spent three days at a provincial hospital, where we did some training and probably saved the lives of at least two women and one baby. One of the women had been in obstructed labour for 24 hours with her eighth pregnancy and our consultant obstetrician under ether anaesthesia performed a very challenging caesarean section using inadequate instruments, which included blunt scissors and only small swabs. The baby had to be given mouth-to-mouth inflation breaths by one of our midwives, as the only available mask did not fit. Our team also saved the life of an unconscious 19 year old who had been having eclamptic fits intermittently for 24 hours. Our obstetrician was able to perform a challenging Ventouse delivery as her cervix was fully dilated. The local team would in fact have done a caesarean section which would probably have killed her. Miraculously she regained consciousness 12 hours later and went home the following day. Our team then travelled to the capital city where we ran a two-day conference on 'Emergency Obstetric Care' with a day of workshops and a day of formal presentations. 147 medical staff attended – midwives, medical officers and anaesthesia providers. It was generously sponsored by the UNFPA

I think small multi-disciplinary teams visiting hospitals in Uganda for one to two weeks to work alongside the local midwives and medical officers could actually make a difference. It would certainly save the lives of a few women and babies. The Ministry of Health (MOH) needs to improve the supply of essential drugs and equipment, increase staffing levels and provide CME for the midwives and the doctors, making sure the latter are paid on time and have experienced specialist back-up available to attend when needed. Midwives should be allowed to choose where they work after completing their training rather than being told where they must go by the MOH. In spite of staff shortages there are apparently many unemployed midwives who for family reasons are not prepared to move to provincial hospitals.

Changing an entrenched system is not easy but perhaps we NHS employees involved with maternity in the UK ought to consider what we could do to just help a few women in parts of the world where the chance of dying during pregnancy or childbirth is at least a100 times greater than it is in the UK.

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