# The Baby-Saving SISTERHOOD

**While giving birth in the UAE is relative luxury, not every woman has access to state-of-the-art healthcare. This Mother's Day, VIVA meets the expat midwives and doctors delivering babies in some of the world's most deprived places...**

Outside a remote health clinic in Dera Murad Jamali, a rural village in the Balochistan region in south-west Pakistan, a heavily pregnant girl is lying in agony on some straw in the back of a battered truck. Having travelled for three days to reach the health clinic, she is completely exhausted, too weak to push the baby out and drifting in and out of consciousness. Suddenly, her body starts to spasm violently as an eclamptic fit, caused by life-threateningly high blood pressure, takes hold – for the second time.

As the teenager's frail body jerks so forcefully she passes out, Dr Marianne Stephen, 30, jumps into action. Clearing the girl's airways, she administers drugs to stabilise her blood pressure before rushing her to theatre and delivering her baby safely.

Scenes like this are all too familiar to Marianne, an obstetrics doctor from Glasgow, Scotland. Last year, she spent six months working for Médecins Sans Frontières (MSF) in this health clinic's maternity unit. In the UAE, only one in 100,000 women will die during pregnancy or childbirth* but in Pakistan, the maternal mortality rate is 260 times that and six babies in every 100 die at birth.

## 'I have seen women show up when it is too late to do something'

In rural regions like the one where Marianne was based, women traditionally give birth at home, only seeking medical attention if there is a serious problem such as heavy bleeding – one of the major causes of women dying in childbirth – or in this teenager's case pre-eclampsia, brought on by high blood pressure. But unfortunately, by the time they travel up to three days on a rickshaw, donkey cart or in the back of a truck from their remote villages to the maternity clinic, it is sometimes simply too late.

"This girl had been unwell for three days," recalls Marianne. "By the time she got to us she was unconscious. If she had had a third fit, there is a danger of brain damage because of the lack of oxygen. Luckily, we were able to stabilise her enough to deliver her baby safely, and with the right dose of medication, she recovered within 24 hours."

But as Marianne knows only too well, not every Pakistani mother is as fortunate.

Dr Marianne Stephen with midwives in Pakistan

## Battling the odds

"A lot of women die in childbirth in Pakistan," says Marianne. "One of the reasons for this is that the local women have a lot of children, and the risks are greater the more children you have. They have a higher risk of bleeding after they have the baby. I met one lady who was delivering her 20th baby."

What's more, with a severe shortage of skilled birthing attendants in rural areas, easily treatable conditions such as pre-eclampsia are not spotted until the woman's condition gets so extreme that she starts to fit.

"Occasionally, I have seen women show up to the clinic when it is too late to do something," says Marianne. "But with simple antenatal care, we can spot pre-eclampsia before women go into labour, so they aren't getting to the point where they are fitting."

Another issue in the developing world is malnutrition, which can leave some women with under-developed pelvic bones that are too small to allow the baby through. In the worst cases, the baby gets completely stuck. In extremes, this can lead to the death of the mother or baby – a distressing situation that Marianne has experienced first-hand.

"I had one particular lady who had an obstructive labour – the baby wasn't in the right place and was stuck in the pelvis," says Marianne. "When that happens the womb of the tissue is very soft and can easily tear. The operation was extremely difficult, and the mother bled so much that she started clotting. In the end, we were able to save the baby, but the mother died.

"You have to prepare yourself for the bad, but when it happens it is very difficult to see."

## Fighting for change

MSF has been working to reduce the risks to mothers in Pakistan by improving access to screening, skilled birth attendants and neonatal care. They also work to supply simple drugs such as Misoprostol, used to stop heavy bleeding after birth, and Magnesium

Jacqueline McAuley was shocked by conditions in Ethiopia

Sulphate, which treats the pre-eclampsia that can lead to fits, brain damage and even death.

A large part of Marianne's work in Pakistan was to train local midwives on how to administer these drugs, which are readily available to women giving birth in the UAE. But then, with private birthing suites, pain medication at the touch of a button and personal midwife care, women in the UAE can give birth in relative luxury.

In many parts of the developing world, the situation can be very different. Jacqueline McAuley, 32, a midwife from Carrickfergus, Northern Ireland, spent 20 months working

## 'I loved seeing my students have that lightbulb moment'

in a maternity hospital in Gondar, Ethiopia, with development charity VSO International. The hospital served a population of five million and had just 24 maternity beds and limited access to running water.

"It was very over crowded so when the women came to hospital, they often did not have a bed. They would be on a mattress on the floor," says Jacqueline. "Potentially if it was very busy, you would push two mattresses together and have one lady in labour at the top, one lady at the bottom and one lady in between the two mattresses – so three women and their babies would be sharing two mattresses, which were often soaked in blood. We didn't always have running water in the hospital and that was a huge issue for maintaining hygiene."

## Spreading the word

But hospital conditions were not the only thing that shocked Jacqueline when she first arrived in Gondar – cultural gender issues, overcrowded hospitals and stressed out medics created a dangerous mix. "When I first arrived, the women in hospital were really being treated very badly. This would sometimes involve verbal and physical abuse whilst they were in labour," says Jacqueline. "When I first started, I saw one male medic strike a labouring woman. I was shocked and horrified to watch someone physically abuse a patient. I grabbed his hand and screamed at him to stop."

Part of Jacqueline's role was to eradicate this kind of behaviour by equipping the local health professionals with proper training. "We ran workshops with local nurses and midwives where we discussed professionalism. We asked them to reflect on their practice by asking 'What does it mean to be a midwife or a nurse? What is good care and what is bad care?'"

Jacqueline was also heavily involved in more practical training, including showing local staff how to operate equipment, monitor patients and administer drugs effectively. This included teaching them how to read a partograph – a chart developed by the World Health Organisation that can identify if a woman's labour is progressing normally.

"I was ensuring that my students and colleagues knew how to use the partograph properly and appropriately so they could identify prolonged and obstructed labour," says Jacqueline. "If a labour is prolonged, the woman could develop a fistula as a result of obstructed labour."

Currently, for every 100,000 Ethiopian women giving birth, 276 will die – but Jacqueline is hugely confident that through proper training of local staff, this number can be reduced. "It's about building the capacity of your colleagues, students and peers. It's not just a sticking plaster solution.

It is much more effective in the long term. I spent a long time there and built up some really strong relationships. I saw my students have that 'lightbulb' moment where something I was teaching them just clicked and they understood. And that was extremely rewarding to see." ●

**For more information on Médecins Sans Frontières, VSO international or Amref, visit www.msf-me.org/en, www.vso.org.uk and www.amref.org**

Esther Madudu, 32, works at Tiriri Health Centre, Eastern Uganda, where she is one of just two midwives serving a population of 30,000 people. She is the face of African charity Amref's Stand up for African Mothers Campaign. "Tiriri is deep in a rural area. There is no fence around the health centre, it has had no power for some time and the solar panels do not work. This makes our work very difficult, particularly in the maternity ward. Amref gave us head torches that we use at night. Saving the lives of mothers and children is my biggest motivation. I have supported safe deliveries for more than a thousand mothers and babies already. I remember a baby girl born with her buttocks out first. It was one of the most difficult deliveries I have been involved in. It took such a long time and the mother was in agony. When the baby was born she had to be resuscitated. When she pulled through, they named her after me. My job goes beyond delivering babies. It is about getting proper information and services to people who need them most, and advocating for maternal health to be prioritised. I want the entire world to understand the need of mothers and the need for more trained midwives."

## 'WITH NO POWER, WE DELIVER BABIES BY TORCH LIGHT'

FEATURE AOIFE STUART-MADGE. PHOTOGRAPHY CORBIS. BEN LANGDON. PK LEE/MSF. *STATS FROM THE WORLD HEALTH ORGANISATION.