

Keeping New Mothers Alive

In Haiti and Rwanda, Reducing Tragedy in Childbirth



Bernadette Valerus, 33, left, a mother of seven, collects her weekly supply of baby formula at Las Cahobas Health Center, run by Partners in Health and the Haitian Ministry of Health. (By Daniel Morel -- Associated Press)

By Paul Farmer and Ophelia Dahl
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"Obscene" is still the word that comes to mind when we think of maternal mortality -- and it has been almost 25 years since we first witnessed death in childbirth. In 1983, as students in one of central Haiti's fetid clinics, we prepared to celebrate a birth. Although we'd just met the young woman about to become a mother, her desperate expression as she began to hemorrhage haunts us still. National statistics could have predicted the outcome: A 1985 survey pegged Haitian maternal mortality at 1,400 deaths per 100,000 live births. By comparison, maternal mortality in the United States last year was 14 deaths per 100,000 live births.

Worldwide, 500,000 women die in childbirth every year; more than 90 percent live in Africa or Asia, and almost all are poor by any standard. Obscene though it is, death during childbirth isn't the end of the story. In the world's poorest areas, many orphaned children wind up destitute and on the streets within a few years of their mothers' deaths, sometimes resorting to desperate or criminal measures for food, shelter, clothes or school fees.

One of the 12 U.N. Millennium Development Goals is to reduce maternal mortality 75 percent by the year 2015. But we are moving too slowly to meet this goal, the United Nations says.

Today, the maternal mortality rate in Haiti is less than half what it was a quarter-century ago. Across the broad swath of central Haiti where we work, we estimate the number to be well below 100 deaths per 100,000 live births -- not good enough but a vast improvement, most of it occurring in the past decade. Change came largely for three reasons.

First, our nonprofit organization, Partners in Health, has worked closely with the Haitian Ministry of Health to strengthen public health infrastructure. We have rebuilt, equipped, staffed and stocked hospitals and clinics; trained nurse-midwives and other personnel, including more than a thousand community health workers; linked villages and health centers to district hospitals

by modern telecommunications and ambulance service; and established modern surgical services for obstetrical emergencies.

Second, we have broken the rule that high-quality health services are a privilege rationed by ability to pay, not a right. The case was made first for affordable medicines. Now it is being made for emergency Caesarean sections -- an essential tool to reduce maternal mortality. Faced with evidence that maternal mortality was greater where fees were higher, the district health commissioner for central Haiti announced last August that all prenatal care and emergency obstetrical services would henceforth be available free to all patients. He was later echoed by Haitian President René Préval.

Third, we have linked prenatal and obstetric care to an all-out effort to improve access to primary health care. The presence of functional, accessible public clinics and hospitals restores faith in the health system, motivates people to seek care before they are critically ill and allows for preventive interventions such as prenatal care and family planning.

Consider Rwanda, another country where we work, which is rising rapidly from its ashes scarcely a dozen years after an appalling genocide. Rwandan maternal mortality rates in 1995, the year after the genocide, are unknown. But they are sure to have exceeded the 1,800 deaths per 100,000 live births reported that year in relatively peaceful Malawi. The situation has improved dramatically since then.

By helping to train and, importantly, pay community health workers, the Rwandan Ministry of Health is taking steps to link rural villages to health centers with the capacity to make routine labor safe. Rwanda is also seeking to make family planning available to citizens and to increase access to preventive and primary care through basic health insurance. Maternal mortality has dropped from more than 1,000 deaths per 100,000 live births between 1995 and 2000 to less than 600 today -- still terrible but well below the average (940) reported for sub-Saharan Africa.

At the government's invitation, Partners in Health launched efforts to strengthen AIDS treatment and primary health services in one region of rural Rwanda in 2005. Mindful of the lessons learned during two decades of work in rural Haiti -- and of that young Haitian woman whom we watched turn abruptly from the anticipation of new life to a confrontation with death -- we have made reducing maternal mortality and improving women's health top priorities. And we have welcomed the opportunity to support Rwanda's commitment to breaking the cycle of poverty and disease by including health care and education (especially for girls) in its vision of the future. It's probably no coincidence that Rwanda also boasts the world's highest percentage of women in parliament.

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