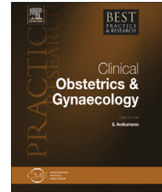
Best Practice & Research Clinical Obstetrics and Gynaecology xxx (2016) 1–11

Contents lists available at ScienceDirect

Best Practice & Research Clinical Obstetrics and Gynaecology

journal homepage: www.elsevier.com/locate/bpobgyn



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Global maternal health and newborn health: Looking backwards to learn from history

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Keywords:
maternal mortality
stillbirth
neonatal mortality
tropical medicine
demography
human rights

The late appearance of the 'M' on the international health agenda – in its own right and not just as a carrier of the intrauterine passenger – is thought-provoking. The 'M' was absent for decades in textbooks of 'tropical medicine' until the rhetoric question was formulated: 'Where is the "M" in MCH?' The selective antenatal 'high-risk approach' gained momentum but had to give way to the fact that all pregnant women are at risk due to unforeseeable complications. In order to provide trained staff to master such complications in impoverished rural areas (with no doctors), some countries have embarked on training of non-physician clinicians/ associate clinicians for major surgery with excellent results in 'task-shifting' practice. The alleged but non-existent 'human right' to survive birth demonstrates that there have been no concrete accountability and no 'legal teeth' to make a failing accountability legally actionable to guarantee such a right.

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Looking backwards to learn from history is always a useful exercise. The author has opted to trace a few initial leads, entitled 'Where was the "M" … ?' By doing this, the point of departure is Rosenfield's and Maine's now classical article from 1985 – more than 30 years ago – *'Where is the "M" in MCH?'* [1]. Because this chapter is retrospective, the author chose to write these leads in the past tense as an ingress to this retrospection: tropical medicine, demography and maternal and child health (MCH).

Where was the 'M' in tropical medicine?

Since the inception of the discipline 'tropical' medicine, its textbooks almost never paid any discernible attention to maternal health per se, even if it was obvious to all 'tropical' doctors that

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http://dx.doi.org/10.1016/j.bpobgyn.2016.05.010
1521-6934/© 2016 Published by Elsevier Ltd.

Please cite this article in press as: Bergström S, Global maternal health and newborn health: Looking backwards to learn from history, Best Practice & Research Clinical Obstetrics and Gynaecology (2016), http://dx.doi.org/10.1016/j.bpobgyn.2016.05.010

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obstetric problems were – and are – extremely common and that the toll taken by maternal and neonatal ill health in the "tropics" was – and is – enormous [2]. For decades, textbooks in tropical medicine have notoriously omitted obstetrics. This is strange as the vast majority of all maternal and perinatal deaths occur in 'tropical' countries.

As a 'tropical' doctor 40 years ago during the war in Angola (1975–76), the author discovered that studying textbooks in tropical medicine never gave any information on issues that are very prevalent in the 'tropics' such as eclampsia, obstructed labour, postpartum haemorrhage, maternal mortality or stillbirth. We can, for instance, certainly assume that any world epidemiology map of eclampsia incidence would be reasonably similar to the corresponding map of, for example, malaria. Still the word 'eclampsia' could never be encountered under 'e' in the index of textbooks in 'tropical' medicine.

From the beginning, specialists of 'tropical' medicine in European countries were not *specialists in medical problems in the tropics* but rather merely experts in 'travel medicine', essentially taking care of (homecoming) Europeans' 'tropical' diseases. Of course, there were no homecoming travellers with eclampsia, obstructed labour or postpartum haemorrhage. So this bias is an important reminder of the character of textbooks in 'tropical' medicine 40–50 years ago and very often even today.

In fact, it is well known that several countries in the tropics – such as Cuba – have a 'tropical' disease pattern quite different from other countries at similar latitudes. At the same time, we know that in some currently high-income countries very far from the tropics, for example, Sweden, malaria, leprosy, cholera, etc. were rampant 200–300 years back, making these diseases hardly 'tropical' but rather diseases of poverty. The expression *'pathology of poverty'* has been coined to illustrate this association [3]. The difference in perception – considering today's Cuba and historical Sweden – also represents an attitudinal shift in understanding the complexity of 'tropical' diseases caught in the rhetoric question: *'their latitudes or our attitudes?'* [3].

Currently, the perception of 'global' medicine has widened the scope not only geographically but also discipline-wise, and maternal and neonatal health has entered the field in an appropriate way [2,4]. We have turned our attention from the tropics to the planet as a whole, and by that maternal and neonatal health has appeared as two obvious priority fields of intervention.

Where was the 'M' in the 'baby bomb' era?

Looking backwards, it is obvious that the late recognition in low-income countries of maternal and neonatal ill health in general has to do with the powerful setting of priorities by influential donor countries and international organizations. The demographic focus on 'the population explosion' rather undermined any donor interest to reduce maternal mortality or to pay attention to maternal and neonatal health [5,6]. One particularly revealing example is from a meeting of all Scandinavian professors of obstetrics and gynaecology in Uppsala, Sweden, in the late 1980s. When the author lectured on the need to reduce maternal mortality, a question came from one of the most prominent Swedish professors in obstetrics and gynaecology at the time: *'Would not reducing maternal mortality imply that the population explosion will worsen?'* He was not alone in seeing enhanced maternal survival as potentially dangerous and problematic. But he was ignorant about the fertility trends showing, already then, the levelling off of global population growth. Notwithstanding this, the mere expression of doubt whether it would be wise to save mothers' lives is of course ethically unacceptable by any standard.

In the 1980s, the 'M' was also virtually invisible in research priorities supported by major international donors. Less than 5% of the funding in 'reproductive health' research in the HRP (Special Programme on Research in Human Reproduction) was spent on maternal health; the remaining bulk supported contraceptive research (Sterky, personal communication).

The Swedish professor's questioning of the wisdom of reducing maternal mortality is a thought-provoking illustration of the famous statement by Professor Mahmoud Fathalla, quoted innumerable times:

> *'Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.'*

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