Summary

The global scientific and political communities have been remarkably unsuccessful in reducing the number of African women who die or sustain serious disability from pregnancy and childbirth. Limited access to proper medical care is a major factor contributing to this failure (chapter 1).

The situation in Thyolo District, Malawi, is no exception (chapter 2). A sisterhood survey, which relies on participants answering questions about maternal deaths within their families, determined that the community-based maternal mortality ratio (MMR) was 558 per 100 000 live births in 2006 (compared with 12 per 100 000 in the Netherlands) and had increased from 409 per 100 000 since 1989. At the hospital, the MMR was even higher at 994 per 100 000 live births. These figures are likely to underestimate the true maternal mortality (chapter 3).

Systematic obstetric audit of maternal complications, involving district health workers and managers, was initiated to reduce maternal complications at the health facility. Plenary discussion of care given in critical cases allowed participants to suggest improvements and receive direct feedback. In the first year after the implementation of these audit sessions, the incidence of uterine rupture declined from 19.2 to 6.1 per 1000 hospital deliveries (chapter 4). Over the complete two years of the 4M-study (study of maternal mortality and maternal morbidity in Thyolo), the number of serious maternal complications declined from 13.5 to 10.4 per 1000 facility deliveries in the district (chapter 5). Health workers were eager to take part in the audit and considered it an important activity, especially for its educational value (chapter 6).

Important contributing factors, including substandard care, could be identified by reviewing large numbers of different maternal morbidities. Review of haemorrhage cases showed that unnecessary caesarean sections on lifeless fetuses were a common avoidable factor contributing to substandard care (chapter 7). Review of cases of infection showed how infections not directly related to pregnancy contributed to maternal mortality and morbidity, and that timely uptake of antiretroviral treatment lowers the chances of HIV-positive women dying from peripartum infections (chapter 8).

Although morbidity review appears to be useful for measuring and comparing morbidity across settings, there are no standard criteria for severe maternal morbidity or ‘near misses’. The World Health Organization intends to develop standard criteria, but the organ-specific criteria it has proposed require sophisticated diagnostic capacity, which is not available in under-resourced settings such as Thyolo. Therefore these criteria do not appear to be reliable for comparing morbidities across different settings (chapter 9).

Towards the end of the past millennium, HIV infection became one of the main contributors to maternal mortality and morbidity. With external support, access to antiretroviral treatment has increased tremendously in recent years (chapter 10).
Despite rising fears that the increased attention to HIV may be to the
detriment of other health priorities, including maternal and child health, the
uptake of peripartum care, family planning services, and treatment of sexually
transmitted infections in Thyolo increased during the ‘scaling up’ of HIV services.
It must be noted that HIV services were increasingly integrated with general
reproductive health services, meaning that antiretroviral therapy and prevention
of mother-to-child transmission services were increasingly provided at the same
clinics, during the same hours, and by the same staff as general reproductive
health services (chapter 11). The number of women delivering at formal health
facilities doubled over two years after implementing an incentive of soap, a baby
blanket, and a traditional cloth wrap, financed from HIV-funds (chapter 12).
Antiretroviral therapy improved the survival of health workers themselves,
increasing their availability within the health system (chapter 13).

Despite these achievements, significant improvements in the lives of African
women are likely only when they start claiming their right to better care. An
educational activity such as an obstetric audit may facilitate this by increasing
the human dignity of every patient entering a health facility (chapter 14).