"Global aspects of women's health"

The Sir George Pinker Memorial Lecture by Archbishop Vincent Nichols

Wednesday 12th October 2011

I never had the privilege of meeting Sir George Pinker, but reading Roger Marwood's tribute to him I was particularly struck by two things. One is the well-known story of the house manager at Covent Garden trying to locate him urgently in a crowded bar during an interval in the opera. To the cry "does anyone know Mr George Pinker?" most of the women present put their hands up.

The second, more seriously, is Roger Marwood's description of what he had learned from him as a doctor:

"I learnt from him always to keep the patient at the centre of any clinical situation – especially when teaching. He gave his patients his absolute individual attention and treated all women with the same dignity and respect whatever their circumstances. They all got as much time as was required. Even though he could be running an hour behind schedule, his patients did not mind. They knew that they too would get as much of his time as they needed."

That moral principle – that all women –indeed every human being - should be treated with the same dignity and respect whatever their circumstances - is the basis of what I want to speak about this evening. I would like to focus mainly on one aspect of women's health worldwide, namely maternal health, before concluding with some thoughts closer to home about the role of healthcare professionals from a Christian perspective.

Each of us is only here this evening because a woman gave birth to us. The extraordinary miracle of motherhood is part of the origin of every human life. Yet so too is the risk of maternal mortality or morbidity. But the extraordinary advances in your own specialism, which George Pinker did so much to promote

and sustain, have helped dramatically to reduce the risks in this and other developed countries.

In our world today, as you will know, each year somewhere between 350,000 and 500,000 women die in childbirth. A further 300 million suffer from avoidable illness and disability. The odds that a woman will die from complications of pregnancy and childbirth in some of the poorest countries can be l in 20 compared with a ratio of 1 in 7,000 in some countries in the developed world.

As a non-expert reflecting on these problems three things immediately stand out. One is the impact on the poorest societies of persisting high maternal mortality ratios. Second is that it is largely preventable. And third, that progress on improving maternal health, which was one of the key millennium development goals (MDGs), has been so tragically slow.

A death of a mother, during pregnancy or childbirth, has a devastating impact on families and communities, and particularly on surviving children: a newborn baby is three to ten times more likely to die within its first two years without its mother. In many poor countries the health of women is critical to social, economic and political development.

The 2011 report on the MDGs notes that *"the vast majority of maternal deaths are preventable.... Studies have also shown the likelihood of maternal death increases among women who have many children, are poorly educated, are either very young or very old, and who are subjected to gender discrimination".*

The report goes on to note that what is crucial to reducing maternal deaths is the presence of a trained health-care worker during delivery. Countries that have improved their levels of access to a skilled nurse or doctor at birth with effective referral to emergency obstetric care have successfully reduced maternal mortality. It should not surprise us then that there is a strong correlation between how high the maternal mortality ratio is, and how poor the health system is in a country.

Given the importance and the magnitude of the problem, and given that we know what it takes to dramatically improve the situation, why is progress so

slow? The picture is mixed. Some countries, including some very poor countries such as Nepal and Bangladesh, have seen some notable improvement. Africa has seen the least progress of all. Of course, HIV in Africa has been a tragedy which has greatly set back the capacity of many countries to improve. But beyond this lie broader social, political and cultural factors: the status of women and the low priority given to their health, a failure to accord women the dignity and respect needed. Attitudes to women in poor countries directly contribute to maternal mortality in many ways, such a failure to nourish girl children, poor education, or coerced sex contributing to unplanned pregnancy. The low status of women and their marginalisation can contribute to their lack of access to health services: an estimated two million women suffer from unrepaired fistulae, with the long term stigma and distress this causes.

In many of these very poor countries we are also, of course, dealing with fragile or failed states with a concomitant lack of political capacity to achieve change.

But taking all these factors into account, when we consider the effort and resources made available and focussed on other challenges of disease facing the developing world, maternal health has clearly not been given the priority it manifestly needs. Funding for maternal and child health amounts to only 2% of current development aid, a small fraction of world spending.

Last year the Canadian government recognised the slow progress made toward the Millennium 2015 goal of reducing by 75% the maternal mortality ratio from its 1990 level. Commendably it used its leadership of the G8 to launch the Muskoka Initiative to pledge significant extra funding to maternal and child health. This is something which has been strongly supported by the UK government since that time. It is to be hoped that the donor government pledges then made are fulfilled. Of course the governments of poor countries also have a crucial role, and there are examples which have demonstrated that progress is possible, relatively quickly, in reducing child and maternal mortality.

Faith communities and the health professions in other countries also have a vital contribution to make. They can press for a decrease in the tolerance and

acceptability of avoidable deaths. They can advocate better management of resources, build up evidence and accountability, form public opinion and involve and strengthen civil society. Indeed maternity and community/society need holding together since motherhood is foundational for every community. In many developing countries, in particular in some of the most deprived areas of the world, the Catholic Church and other faith groups make such a significant contribution to health care. They are often able to reach the most vulnerable women in the remotest areas. Let me give you one example. Sr Lucy O'Brien was a sister of the Holy Rosary Congregation. She was an obstetrician and gynaecologist who spent 40 years in Zambia until her death in 2006. She was described as a tiny, birdlike woman whose skill resounded from one end of Zambia to another. Working with Professor John Kelly of Birmingham she developed an extraordinary reputation. Let me recount briefly this moving description of her work:

"A village woman with a fistula approaches a clinic or hospital at a time when she is least likely to encounter others. She is ashamed of something that is no fault of her own. She is afraid of the reactions of other people. She expects, once again, to be rejected and yet neither can she completely extinguish the tiny flicker of hope that, somehow, life might still hold happiness. The beauty of a woman such as Sr Lucy was that she not only greeted her female patients as fellow human beings, she was also unafraid to come close and to touch them. With a few words and several minutes of one-to-one attention, she could offer hope. That was one reason why even the illiterate women from the most remote villages, when they heard of her, would make their way to Monze hospital in the hopes that Sr Lucy, with her medical skills, would perform some sort of miracle. With her greater than average skill in this specialised field, miracles did happen. But perhaps the greater miracle was not in restoring a physical condition. There is something wonderful about seeing a woman once again walk tall, dignified and in the company of others. It is something of a miracle to see her smile again and to know that she has found happiness. That was Sr Lucy's special missionary gift: her 'woman's touch' helped other women recover their smile."

Her example is repeated many times in the lives of Catholic religious sisters, not least from this country. A number of them have taken the trouble to tell me of their own experiences when they heard that I was giving this address.

In some African countries, 40% of health services are provided by the faith based sector. However many of these services are poorly equipped and their health care workers in need of further education and training. Because of lack of funds some providers are forced to charge for their services, which are a significant barrier for the poorest and most needy (often women and their children).

At present no more than 40% of births in low income countries are assisted by properly skilled attendance. There is not only a great shortage of midwives, and medical specialists, but also a need to develop a continuum of care with higher levels of competency through appropriate training, clinical instruction and mentorship, with more female staff. I was also struck by the finding of one study that countries with high maternal mortality rates commonly also lack a professional association of obstetricians.

It is very encouraging to see the active engagement which the Royal College already has on capacity development through training, exchange programmes, provision of guidelines and setting standards that are relevant to the local circumstances, including the crucial cooperation with associations of midwives. I know that many of your members already contribute some of their time and expertise precisely to help build such capacity and to transfer their skills to others. And not least of the needs is to export the excellent practice whereby women delivering their babies are treated with respect and dignity, and fully involved in decisions about their care. I would be glad to do anything I can to explore ways of promoting such exchanges to support maternal and child health services in areas where the Catholic Church is involved in providing healthcare services, especially in Africa.

This is not to say that everything is rosy here in the UK. A recent BMJ editorial noted that even in the UK today women die in childbirth from preventable and treatable medical causes and we still have areas in the UK where the infant death rate is the same as much lower income countries. In Birmingham, my

former diocese, and the poorer parts of the diocese of Westminster, there are infant mortality rates much higher than the UK average.

The Church is involved in the provision of healthcare in developing countries in direct response to its mission to serve those in need. Good health is a key aspect of justice, and women and children are globally those who experience most injustice in access to it. But there is also a further dimension to the Christian approach to the problem we confront, which is powerfully expressed in a document produced in 2009 by Pope Benedict as a way of evaluating secular economic and social systems through the moral lens of charity. He wrote this:

"The risk for our time is that the de facto interdependence of people and nations is not matched by ethical interaction of consciences and minds that would give rise to truly human development. Only in charity, illumined by the light of reason and faith, is it possible to pursue development goals that possess a more humane and humanizing value. The sharing of goods and resources, from which authentic development proceeds, is not guaranteed by merely technical progress and relationships of utility, but by the potential of love that overcomes evil with good (cf. Rom 12:21), opening up the path towards reciprocity of consciences and liberties" (Caritas in Veritate, 9).

Pope Benedict's words invite us to look deeper into what makes life whole, and to recognize and confront the challenges of our day which dehumanise. Inequity, the fact that caring and compassion are under strain, and the tendency of technology and market systems to undermine a person-centred approach, all increase the risk that the 'human' can go from healthcare. And when the 'human' goes, as reflections on professionalism from another Royal College[1] considered recently, so too may professionalism and many other vital elements of the healthcare process.

Anyone who casually reads any of the Gospel stories will be struck by how central a role the healing miracles of Jesus play in his ministry. Two things stand out about them. One is that they are always the result of a personal encounter – Jesus never healed a crowd. And, secondly, they always also

[1] Royal college of physicians professionalism debate

relate to faith, and are seen as being restorative spiritually as well as physically and mentally. "Your faith has ***made you whole***". The effect of the encounter is that through Jesus' actions God's kingdom is revealed and the person made whole – renewed and restored in God's image. These miracles are signs that Jesus restores a frail and broken humanity, and draws those healed into a restored relationship with others and with God. They help to reveal to us what it is to be fully human, fully alive. This opens up much wider questions of the relationship between faith and reason in our self-understanding. But this is not the time for them.

The commitment of the Church down the centuries to care for the sick echoes in the names of some of London's great hospitals, such as St Thomas's and St Bartholomew's. Along with these names, the foundation of the professional commitment of healthcare workers today, I would suggest, is in continuity with this long Christian heritage. It is still fundamentally about seeing life whole. We cannot always heal, and sometimes the role of the physician as of the priest is to be with those who are suffering and remain present in times of trial. Both the physician and the patient are changed by their encounter. It is an extraordinary paradox that it is precisely in acts of service to those in need- the quality of care, the depth of compassion we show to others, individually and as a society - that we each become more fully human.

So the role of the healthcare professional must be to put the good, the best interests, of the person being served at the centre of their service, with a deep respect and attentive care of the whole person at the heart of what they do. Such an attitude is the foundation of the trust which people rightly place in doctors, nurses and midwives. The professional of course also brings with them their moral and ethical principles, and no-one can or should be expected to leave these at the door of the place of care.

In this connection I am all too aware as you will be of the very difficult ethical dilemmas which your specialism can produce. In approaching these, as you will know, the Church starts from some very clear and unambiguous principles, founded on the utmost respect for human life from the time of its conception and on a clear-eyed understanding of the origins and destiny of all human life.

Such principles unfold into all sorts of areas and in ways with which some of you will not agree. Many of you will no doubt have thought deeply about these issues in coming to your own view of your clinical practice, and living with the dilemmas that remain. I have no doubt that advances in technology will only add to the complexity of these dilemmas in future. But in this evolving situation your support for the right of conscience will be increasingly important, and I very much welcome the fact that, as your President told me, the College fully accommodates this. In the spirit of the 'open conversation' which this memorial lecture initiates, a continuing dialogue on some of these difficult issues is of mutual benefit to us all.

Underlying all I have been saying this evening is the desire that we try to see life whole: to see the good of the person we are serving and to attend with total respect to the dignity of the woman being treated; to see in the scandal of persisting maternal mortality the moral imperative of action to change it at the service of the mother and the child, of life and humanity; to see also that globally what is needed is, in the words of another Pope, John Paul II, "a true vision of women's dignity and aspirations, and a vision which is capable of inspiring and sustaining objective and realistic responses to the suffering, struggle and frustration that continue to be a part of all too many women's lives". (26 May 1995)

The prestige and leverage of this Royal College puts it in a unique and crucial position in driving forward efforts among professional associations around the world in saving and improving the lives of so many mothers and babies.

Thank you for inviting me, and I look forward to our discussion later.

+Vincent Nichols

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