



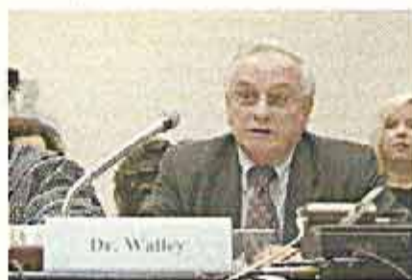
# MaterCare International

*"maternal health care is a human right"*

Spring 2008

MCI Newsletter

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## MaterCare International's Founder and Executive Director Addresses United States House - Urges Support for Mothers in Third World

In mid-March 2008, Dr. Robert Walley addressed the United States House of Representatives Committee on Foreign Affairs Subcommittee on Africa and Global Health, urging the U.S. to spend more to address basic health needs of children and pregnant mothers in the developing world.

Citing the billions of dollars that have been spent on so called reproductive health programmes, Dr. Walley said that maternal health is

the most neglected of the Millennium Development Goals (MDG) the United Nations hoped to reach by 2015. "MDG number 5, 'to improve maternal health by reducing maternal mortality and morbidity by 75%', will not be met for 275 years at the present rate of progress," he explained. "The reasons are poverty, lack of compassion, lack of political and professional wills, a conspiracy of silence, and a lack of imagination (LifeSite News)

(see full text below)

## U.S. House of Representatives Committee on Foreign Affairs, Subcommittee on Africa and Global Health, March 13<sup>th</sup> 2008

I feel deeply honoured to have been invited to be a witness before this committee, for which I thank you Chairman Payne and Mr. Christopher Smith, ranking committee member. Over twenty years ago Dr Alan Rosenfield and Debora Main, published a paper in the Lancet with the title, "Where is the M (mother) in MCH (child). I am happy to be the obstetrician here today to put the M into these discussions on reducing global child mortality.

Mothers, in the developing world, are experiencing "unimaginable suffering" due to scandalous lack of effective care during pregnancy and childbirth with the consequence that many thousands are dying. The World Health Organization claims that there are 600,000 maternal deaths annually of which ninety-nine per cent occur in developing countries. However, there is no accurate data to substantiate these numbers, the reason being that most developing countries do not report information on births, deaths, the sex of dead people or the cause for death. However, figures from my own experience at a mission hospital in Nigeria where the in-hospital maternal mortality ratio was 1,700/100,000 live births illustrates the enormity of the situation.

Some 200 million women are pregnant, world-wide, each year. Most mothers deliver in villages without access to safe, clean facilities in which to deliver and without a trained person to assist them. Most maternal deaths occur during the last trimester and and in the first week following

delivery. Practicing in Canada prior to going to Nigeria in 1981 and since, I had never been present at or had a mother die under my care from a direct obstetrical cause. Maternal deaths in Canada are at the level of what is called irreducible minimums, 1/100,000 live births. However, at the mission hospital maternal deaths were almost a daily event. I recall one weekend during which there were four deaths of mothers who had arrived at the hospital, two in extremis from haemorrhage, one in agony from obstructed labour, and another with a ruptured uterus, after days in labour as she was young and consequently her pelvis was too small. Others would arrive unconscious due to pregnancy induced hypertension or suffering from malaria, or severe anaemia resulting from malnutrition. Most mothers die in Africa alone and in terror in villages, as they have no way of getting to the hospital. Not only are the lives of these mothers abruptly ended but also the lives of their babies, and in the aftermath the chances of survival of their young children decreases dramatically resulting in the disintegration of their families.

Sadly, these deaths represent only the tip of the iceberg. It is estimated that for every death, 30 more suffer long-term damage to their health, e.g. from obstetric fistulae. These occur to young mothers as a consequence of neglected obstructed labour (lack of Caesarean section) and also from cultural practices e.g. Gisiri cuts and female

(Cont'd page 3)

### Upcoming Events

**MCI Volunteer Speaker Training Session (Trenton, ON, Canada)**  
April 19<sup>th</sup>, 2008

**"Making Motherhood Safe" Presentation**  
Toronto, Ontario  
May 21, 2008

**Project Isiolo Fundraising Gala**  
Toronto, Ontario  
May 23, 2008

**MCI Rome Conference**  
November 5-9, 2008

**Current Maternal Health Projects**  
Serabu, Sierra Leone  
Isiolo, Kenya  
Kigali, Rwanda  
Sunyani, Ghana  
Nias, Indonesia

Visit our website

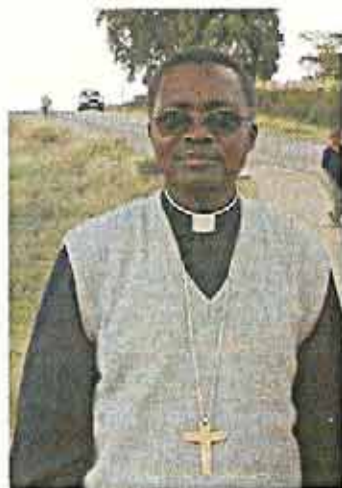
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Rt. Rev. Anthony Ireni Mukobo

## Bishop of Isiolo accepts invitation to travel to Canada

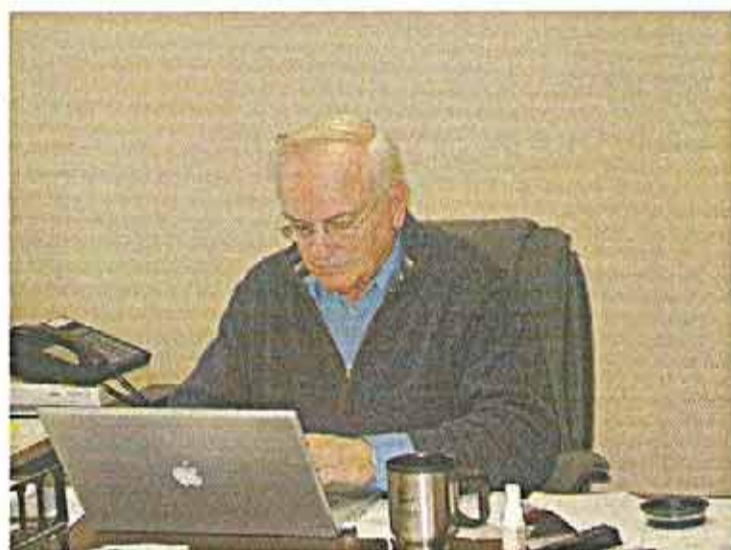
The Bishop of Isiolo, Kenya has gracefully accepted an invitation from MaterCare International (MCI) to travel to Canada in May of this year. Bishop Mukobo will be in the Toronto area for presentations as well as to attend the third annual Dinner and Dance Gala in support of Project Isiolo.

Bishop Mukobo replaced Bishop Luigi Locati in 2005 after Locati was murdered. Bishop

Locati had contacted MCI earlier in the year with a plea to help with the growing maternal mortality and morbidity problem in his Diocese.

Executive Director, Dr. Robert Walley, met with Bishop Locati in March 2005 and developed a project to help the mothers in Isiolo. In 2006, Dr. Walley met with Bishop Mukobo who pledged his support for Project Isiolo.

## "Special thanks to the Walkerton Sacred Heart High School!"



Dr. Walley with the SHHS mug

When one teacher at Walkerton Ontario's Sacred Heart High School heard about MaterCare International (MCI), she knew she had to do something about it. And her students did!

Natalie Vandenberg attended a pro-life dinner at which Dr. Walley was the guest speaker several years ago. She heard about

MCI and the challenges it faces. She told her Church & Culture class about the low priority given to maternal health in developing countries and they were inspired to make a special effort. A bake sale & popcorn sale and a drive for donated Canadian Tire money, a photo of Dr. Walley in the classroom, a presentation by a local volunteer, then an article in the Walkerton Herald Times -- all increased awareness about maternal health locally while raising funds for MCI. The student council got involved as did some students in other classes. Ultimately, \$271 was sent to MCI along with donated Canadian Tire money of almost \$12 as well as a SHHS coffee mug, now proudly used by Dr. Walley himself for his daily cuppa tea at the office in St. John's, Newfoundland.

MCI has many supporters all over the world but this grassroots show of support is particularly heartwarming, demonstrating the kind of education on maternal health that is one of the goals of MCI's work. Although, worldwide efforts of MaterCare have been personally blessed by the present as well as the past Pope, somehow the willingness of these students to devote their energy and time to help the women in developing countries to safely give birth is especially touching. Thank you, Mrs. Vandenberg and her wonderful students!

Theresa Winchester

## MaterCare Australia



MCI Chairman, Dr. Adrian Thomas, with CWL Members

MaterCare Australia was astounded by the response from the Catholic Women's League (CWL) Australia to an appeal for funds to help promote MaterCare International's (MCI) Safe Motherhood programmes around the world. The CWL members around the country rallied to the cause and a total of AUS \$85,000 (approx US\$78,000) was raised, including two anonymous donations of \$5,000 each. A presentation of the cheque was made to Dr. Adrian Thomas, chairman of MaterCare Australia, by Mrs. Mary Schultz, President of the CWL Australia at their Annual Meeting in Adelaide in September 2007.

We are grateful to Mrs. Schultz and her committee for their



Dr. Adrian Thomas receiving cheque from the CWL

endorsement and support of this venture and to the women of CWL Australia for their efforts in raising such a large sum. Dr. Elvis Seman, MC Australia board member, deserves special mention for his initiative in contacting Mrs. Schultz and seeking the CWL's support for MCI. The mission and philosophy of the CWL Australia and MaterCare are virtually identical and we look forward to close cooperation on many issues of common interest, as does MCI with the World Union of Catholic Women's Organizations (WUCWO).

MC Australia also received AUS \$50 000 from a generous benefactor who has pledged \$50 000 each year for 5 years.

## U.S. House of Representatives Committee on Foreign Affairs, Subcommittee on Africa and Global Health, March 13<sup>th</sup> 2008 (cont'd)

circumcision. The result, because of damage to the bladder and rectum, they become incontinent of urine and/or faeces (obstetric fistulae). Consequently, they are complete outcasts and are treated worse than lepers by husbands/partners, families and societies, simply because they are wet, filthy and offensive. They suffer pain, humiliation, and lifelong debility if not treated. World-wide perhaps 2 million of these poor, young and forgotten mothers are living with the problem mostly in Africa. Reliable hospital data in Ghana puts the incidence of obstetric fistula as 2% of all births. These deaths of mothers and babies are the greatest tragedies of our times especially since they are readily preventable and treatable. Obstetric fistulae can be treated surgically but at present there are insufficient trained doctors, nurses or specialised hospitals. The problems of maternal health, and the need for improved health care has been discussed by the international community for years, most recently as Millennium Development Goal (MDG) No 5, to improve maternal health by reducing maternal mortality and morbidity by 75%. It is admitted by the UN and the international health community that this goal is the most neglected of all the MDG's. A report in the British Medical Journal in July 2007 commented that at the present rate of progress the MDGs will not be met for 275 years i.e. 2282 and not in 2015 as intended. The reasons are poverty, lack of compassion, lack of political and professional wills, a conspiracy of silence, and a lack of imagination.

The consensus of the obstetrical community is that mothers need essential prenatal care, skilled attendants at all deliveries and specialist care for life threatening complications. While billions of dollars have been spent on so called reproductive health programmes and more is demanded, so it is proposed to take funds from HIV prevention and treatment programmes, only a small fraction is focused on providing the services that ensures mothers and their babies survive pregnancy.

In my experience mothers, in Africa are optimistic and want to have babies as they know they are the future of their families, communities and countries. Mother in developing countries do not expect to die or to suffer birth injuries and those who die obviously have no voice, only ours, to plead their case for adequate care, care of the sort mothers have access to in the United States of America and Canada, which is second to none, but is frequently taken for granted. We are all too familiar with the violence caused to women by commission e.g. by sexual assault, genital mutilation and torture but this neglect of mothers is violence as the result of omission.

MaterCare International (MCI) was established in 1995 by obstetricians' particular concerns about the tragic state of maternal health in developing countries. MCI has extensive experience in West Africa, in particular Nigeria, Ghana, Sierra Leone, Rwanda and Kenya, working with local Churches that provide 30 - 40 % of the beds and with local colleagues. In addition to providing much of the health care in rural areas in African countries, these faith based hospitals have for many years enjoyed the confidence and trust of mothers and their families. MCI's approach has put into practice the old obstetrical adage that live, healthy, mothers produce live, healthy, babies. As a consequence, MCI has developed a model of comprehensive, rural, maternal health care based on local causes of mortality and the circumstances under which they occur.

This model, based on the organisation of health services in rural areas of the Province of Newfoundland for over 50 years, is a way of taking essential obstetrical services, found usually only in hospitals, closer to the mother. It provides, at a small, 30 bed mission hospital; full prenatal care, with treatment for common medical conditions e.g. malaria, HIV and severe anaemia, with immunization against tetanus, and specialist management of life threatening

obstetrical complications, with for example caesarean section, and blood transfusion. The hospital is linked by radio to an emergency transport which can go to the mother with life threatening complications with the equipment needed to resuscitate her and then to transfer her to the hospital in a safe and timely manner. The hospital is linked to rural clinics, staffed by trained midwives also providing pre and post-natal care, safe delivery and early referral of complications. A training programme for doctors and midwives in emergency obstetric is provided, and traditional birth attendants (TBA'S) are taught to identify and refer mothers at risk to the nearest clinic. It is known that at least 15% of normal pregnancies and labours may run into complications, so the radio and transport system is able to meet these emergency needs.

This model was developed in Nigeria in the early 1990's and refined in Ghana where it has been functioning since 1997. Evaluation has shown an increase in referrals to the hospital of mothers with complications and thus it may be inferred that maternal deaths have been reduced. The cost of running this sort of programme for 5 years we estimate to be \$2.5 million, Canadian or US dollars, a mere pittance compared with the hospitals in our countries. Our funding proposals, for projects in Sierra Leone, Rwanda and Kenya to government agencies, however have been turned down.

That any mother in the 21<sup>st</sup> century should die having her baby or sustain a birth injury is an international disgrace. This tragedy will only be solved one mother and her baby at a time with appropriate obstetrical care to which she has a fundamental right. A special plea must be included for refugee mothers. Obstetricians know WHAT must be done and for WHOM but their main question is HOW are they going to do it.

Mr. Chairman, this proposed legislation will go along way to helping, for which I thank you, its sponsors and co-sponsors.

### MaterCare back in Ghana

MaterCare International completed its projects in Ghana in 2007. They included a maternal health project in Nkoranza, which provided training for traditional birth attendants, emergency transport, communication between the local hospital and the nursing stations, and a blood bank, all of which are essential for reducing maternal mortality and morbidity.

MCI also conducted research in post partum haemorrhage which accounts for 25%

of maternal deaths. The results were peer-reviewed and published in the British Journal of Obstetrics and Gynaecology

MaterCare also raised funds through foundations and the general public to construct and equip a fistula hospital in Mankessim, Ghana. The hospital was complete in 2007.

In March 2007, the Most Reverend Matthew Kwasi Gyamfi, Bishop of Sunyani,

asked MCI for help to find obstetricians and gynaecologists for his Diocese. Their only obstetrician passed away and presently there is no doctor to continue the maternal health program.

MCI will be recruiting obstetricians and gynaecologists willing to donate their time to the people of Sunyani, Ghana.

The Diocese will provide accommodation while MCI will raise the funds for the costs of travel.

**Help Us Help Mothers, Please donate!**

## Question and Answers with Theresa Winchester (MC Canada)

### MaterCare International

**Executive Director (Founder)**

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**Editor, Public Engagement Director**

*Simon Walley*

**Executive Assistant**

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**Administrative Assistant**

*Sandra Fowler*

**Volunteer Coordinator**

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*Jerry Oser*

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**Spiritual Director**

*Msgr. Maurizio Calipari*



Theresa Winchester

**Theresa Winchester is a retired Major of the Canadian Forces who specialized in Human Resources. A Life Member of the Catholic Women's League of Canada, she has also been a board member of MaterCare Canada for the past 6 years. Theresa has volunteered considerable time as a MaterCare speaker, editing proposals and newsletters, volunteer coordinator, and helping with the organization of conferences and training workshops. Glad to have you with us!**

giving birth. Because my mother had 14 children and never risked her life in giving birth.

**What is the most important thing MCI does?**

That's a very difficult question. Educating government and the public about maternal health in developing countries. Providing a support network for pro-life healthcare specialists. Research into ethical solutions to life issues. Training maternal health specialists. Advocating for mothers of developing countries and giving them a voice in Canada, USA, England, Australia, etc. These are all vital tasks and I'm not sure I can pick out a "most important" as every job becomes crucial when it is not done long enough.

**Where do you see MCI going?**

More voice at the UN and governments everywhere and more people willing to listen.

**How important are volunteers to MCI?**

We simply could not do it all without them. Public education is vital in spreading the word about the need for and work of MaterCare; with volunteer speakers from one coast to the other in Canada, some of this educational burden has been taken from Dr. Walley's shoulders. And yet, there is nothing like having Rob address the group to get their attention and catch his passion!

**When did you first hear of MCI?**

It was at the National Convention of the Catholic Women's League Resolution in St. John's Newfoundland when the provincial president supported the resolution in support of the work of MaterCare. I was immediately taken with the cause.

**When did you first start with MCI?**

On return to my home council, we started the CWL Quilt for MaterCare project. We made a quilt in blue, yellow & white with an old-fashioned quilt square representing every position in the CWL Executive Committee, i.e., "Robbing Peter to Pay Paul" was the Treasurer's square, "Jacob's Ladder" to represent Spiritual Development Chair, "World Without End" to represent the Spiritual Advisor and "Entertaining Motions" to rep the President. Tickets were sold by CWL councils across Canada and almost \$8000 raised. Then Rob & Simon Walley came to Ottawa when we lived there and I went to a government meeting with them and was astounded at the seemingly obtuse answers given to Rob and thought that there just had to be a misunderstanding here somewhere!

**Why do you believe in MCI?**

Because no woman should risk her life in

**MaterCare International (MCI) is an international organization of Catholic obstetricians and gynaecologists and other allied professionals dedicated to the care of mothers and babies, both born and unborn, through new initiatives of service, training, research, which are designed to reduce the tragically high rates of maternal mortality, morbidity, and abortion.**

**Our mission is to serve the Culture of Life where it is most at risk- those crisis areas and 'hotspots' where mothers and their children - born and unborn - are neglected or abandoned outright.**



Maternal Health Care  
is a **Human Right**

**MaterCare International**

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- registered in Canada, the United States, the United Kingdom, Poland, and Australia.
- is the obstetrical arm of the World Federation of Catholic Medical Associations (FIAMC).
- is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC)