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Maximizing Benefits to Mothers and Newborn: an Ethical Analysis of Issues in Newborn Health Program Design

Rashed Shah[1,2*]

[1]Department of Health and Nutrition, Save the Children – US, 2000 L Street NW, Washington DC 20036, USA.
[2]Department of International Health, Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street, Baltimore, MD 21205, USA.

Author's contribution

This whole work was carried out by author RS.

Commentary

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ABSTRACT

This paper highlights on the aspects of bioethics principle of beneficence and equal value of human lives and the concept of distributive justice, mothers and women as seen through the lens of community based newborn health programs in developing countries. The Interagency Group of Safe Motherhood reveals a major reason for what women continue to die from pregnancy related disease is that they are discriminated and that the severe neglect of women's health is a violation of their human rights. Following the bioethics principle of beneficence and to value the equal worth of human lives and the concept of distributive justice, all women including adolescents and pregnant women in same community must have been focused and addressed through a newborn health program. Even within a context with scarce resources, we need to remember that cost sharing and investment on maternal care, particularly antenatal counseling and delivery assistance, helps increasing newborn survival. Estimated over half of costs of newborn health program needs to be invested in maternal health aspects, to ensure effective successful program implementation to improve newborn survival.

Keywords: Ethical analysis; maternal and newborn health program; developing country.

**Corresponding author: Email: mshah@savechildren.org;*

1. BACKGROUND

At a global level, maternal mortality was not recognized as a public-health concern until late in the 20th century. [1] Though there were occasional references in international forum, it was only in 1985, due in no small measure to a provocative article with the title "Where is the 'M' in MCH?" [2] That starkly presented the inherent neglect of women in maternal and child health (MCH) programs, that international attention started to focus on the health of pregnant women. Even then, the programs those focused on maternal and child health were mostly driven by concerns about infant and child health. Interventions for children such as universal immunization, nutritional supplementation, oral rehydration therapy and growth monitoring showed increasing success in bringing down the rates of newborn, infant and child death and disease. If a particular country already has community health workers present at delivery, pragmatism would suggest that they should help mothers as well as newborn babies; for example, by referring women for appropriate care in an emergency. However, no evidence exists that such interventions work at scale. [3] Interventions for pregnant women lagged far behind with little or no attention to women suffering injury or death during childbirth and/or from pregnancy-related causes. Neglected focus to maternal health program needs is also evident at national level; for example, during early 2000s, in Bangladesh, safe motherhood program suffered more challenges in logistic supply and operational support from Ministry of Health, compared to child survival or newborn survival programs.

2. PROBLEM STATEMENT

Ethical tension becomes surfaced while maternal health aspects are ignored and only newborn health issues are prioritized [3,4] in a community based neonatal health program design. The relevant ethical questions include:

a) On which ethical ground 'only neonatal health' intervention would be justified to plan and to what extent such intervention would be successful without maternal health focus?
b) Would it be ethical to deprive mothers from their deserved health rights while they are kept unaddressed in a neonatal health program design?

3. ETHICAL ARGUMENTS

While designing newborn health programs, health planners and researchers remain tunnel-visioned with their focus only on neonatal health risks, ignoring the fact that newborn health outcome is associated with maternal knowledge, attitude and practice, care seeking and utilizing health services during pregnancy, delivery and postnatal period.[4] Keeping women's health issues unaddressed would result in increasing the inequality and unjust to women in the community. Major ethical tension in light of bioethics principle in such discussion includes:

- ***Principle of beneficence:*** Does it harm newborn health if maternal health is ignored?
- ***Principle of respect and autonomy:*** Does it ignore the women's rights to health?
- ***Principle of justice:*** Is it a missed opportunity to reduce burden of health risks in a vulnerable population?

3.1 Key Facts

Globally, estimated 287,000 maternal deaths 3 million newborn deaths and 2.6 million third trimester stillbirths each year represent a huge burden that affects both families and communities. [5] Neonatal health champions often raise their voices for saving newborn lives, without urging for promotion of maternal care. Of course newborn survival is the priority and we should ensure that newborns must not as an orphan. But newborn's mortality risks might not be addressed adequately keeping pregnant women and recent mothers and community members away from adequate health knowledge and counseling and recommended health practice.

Newborns would have been at risk of being sick and death:

- If women don't receive TT immunization during pregnancy; [6].
- If women don't have adequate nutrition, diet and rest during pregnancy and postpartum period; [7].
- If women don't seek health care when they suffer complication related to pregnancy, delivery and postpartum period; [8].

Such evidence-based knowledge makes the ground of ethical tension in community based newborn health program design: Should women and mothers be remained neglected in programs focusing neonatal health? Or be prioritized and cared for or not?

The Interagency Group of Safe Motherhood reveals a major reason for what women continue to die from pregnancy related disease is that they are discriminated and that the severe neglect of women's health is a violation of their human rights. [9,10] It is no coincidence that neonatal deaths account for 40% of under-five mortality rate, since newborn survival is so closely linked to the health and survival of mothers. [11] It is also reported that infants aged 0–5 months who are not breastfed have seven-fold and five-fold increased risks of death from diarrhea and pneumonia, respectively. [12,13] Moreover, estimated over half of the cost for newborn health program needs to be invested in maternal health aspects, to ensure effective successful program improving newborn survival[14]. And evidences reveal that narrow focused program design often misses the opportunity to serve both mothers and newborns through integrated interventions those are proven as effective strategies to ensure optimal utilization of resources [14,15].

3.2 Key Agents

Relevant key agents include pregnant women, recently delivered mothers and newborns, community residents, community health workers, health service providers (from MOH and NGO), Managers and Planners within Ministry of Health (MOH), researchers and policy makers and also the media and mother-child health activists. MOH and Non-Government Organization (NGO) health workers, program planners and policy makers bear the responsibility to ensure individual human rights by delivering health care within the community. Community also has the shared responsibility to support implementing integrated programs and focusing needs of women as a vulnerable population. Media and mother-child health activists should play critical role in community based advocacy and awareness building campaigns to foster improved maternal-child health issues.

3.3 Ethical Analysis

Traditionally a community based newborn health program design tends to include and focus 'only newborn health' issues [15,16]: Ensuring postnatal care, child's immunization, prevention and management of neonatal sepsis. Proponents of such narrowly focused program design and newborn champions often argue –

i. For emphasizing on newborn survival issue
ii. For not targeting too many issues at a time
iii. For optimal resource utilization towards newborn survival only
iv. For not jeopardizing newborn health intervention quality by sharing resources

Other arguments raised by proponents of 'only newborn' focused program include specificity of program objective and the scope of the program.

Arguments from proponents mainly follow utilitarian theory of justice to ensure maximum possible benefits for newborns only as supposed to be specified in the newborn health program scope. The reasonable argument by proponents of narrow focused program intervention is to outweigh simple maternal care elements to increase the newborn survival probability to optimal level. They argue that sharing of resources and community health workers' time for maternal counseling and care may not help pregnant women and mothers much rather may increase newborn mortality risks.

Reasonable disagreement and rationale opponents to these arguments, favoring the comprehensive intervention delivery towards both 'mothers and newborn', mainly follow egalitarian theory of distributive justice. Ethical considerations within this context are –

- Why we should not address pregnant women and thus maternal health, while both mothers and newborns suffer same level of inequality and injustice and
- How babies might be benefitted if pregnant women and mothers are deprived from deserved health care

Following the bioethics principle of beneficence and to value the equal worth of human lives and the concept of distributive justice, mothers and women in same community must have been focused through a newborn health program. We must "value each person's life independently of his or her economic or other value to society or to others, and regardless of social position or stigma". [17] Also the "rule of rescue" is often comes in the discussion of ethical principles in lifesaving interventions. [18] Quoting Dan Brock and Daniel Wikler, we can argue "The world would certainly not be better if people typically had no concern for the suffering of others" [17].

Even within a context with scarce resources, we need to remember that cost sharing and investment on maternal care, particularly antenatal counseling and delivery assistance, helps increasing newborn survival. Estimated over half of costs of newborn health program needs to be invested in maternal health aspects, to ensure effective successful program improving newborn survival [13].

3.4 Program Design Options and Recommendation

Most health sectors in developing countries are strapped for resources, and health causes must compete against one another for scarce funding. [19] still births, neonatal deaths,

maternal morbidity and mortality fit together as public health priorities. Neonatal deaths are more common than maternal deaths and can be reduced through a range of approaches: Institutional or community based, antepartum, peripartum and postpartum [20].

Very limited options are left acceptable on ethical ground as effective to succeed in improving both 'maternal and newborn' care:

3.5 Option 1

An outreach program with equal share of care for newborns and women during their pregnancy, delivery and postnatal period is an option for program design where some basic and essential neonatal care components including clinical management of sick newborns might get compromised. This program would be preventive but may not be sufficient to maternal and neonatal issues adequately. And thus it might reduce efficacy of the intervention and might reduce aggregated probabilities of newborn survival.

3.6 Option 2

Fully focused program for newborn without addressing women and maternal health issues is sometimes appear as an option, though neither recommended nor expected at all. Although preventive in manner as through house-to-house visit, birth surveillance, danger sign recognition but predominantly focused to clinical aspects. This program would increase social inequalities and would fail to address human rights aspect by keeping especially vulnerable group (i, e – women and mothers) out of health care.

3.7 Option 3

Ensuring all basic and essential neonatal care components including clinical management elements for newborns in the program design and adding basic health education and counseling as well as referral services for women in need during their pregnancy, delivery and postnatal period. During household visits, same community health worker (CHW) would provide necessary care for both babies and women during pregnancy, delivery and postnatal period. Only a couple of additional visits during pregnancy would help much ensuring delivery of a healthy baby; some additional time from CHW to counsel mothers for breastfeeding during the same visit for newborn care can significantly increase newborn survival. This option favors distributive justice and maximal beneficence to the community with minimal additional resources. And also would reduce aggregate rate of mortality and morbidities among women and newborns.

I intend to recommend for Option 3 for a community based newborn health program design, which is a reasonable programmatic decision to address basic maternal care components those are linked to improved newborn health and survival. Such an approach to intervene both 'mothers and newborn' may fall under egalitarian theory of distributive justice which would "maximize the sum of individual wellbeing" [21].

4. CONCLUSION

Targeting pregnant women and recent mothers within neonatal health program design, will ensure "a joint call to save the lives of mothers and newborns together through an integrated program approach, and thus will serve the families better, and make enormous benefit of

investing in maternal and neonatal care" [6]. Such an integrated program focusing both mothers and newborns within an overarching design would offer services to both women and newborn and would have aggregative impact on social development and women's human rights and empowerment issues in the long run.

CONSENT

Not applicable.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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