MATERNAL MORTALITY: THE WAY FORWARD

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MOTHER AND CHILD
PRESENTATION OUTLINE

1. INTRODUCTION
2. WHAT IS IT?
3. WHAT ARE THE CAUSES
4. HOW CAN IT BE MINIMIZED
5. CONCLUSION
INTRODUCTION

• PREGNANCY NOT A DISEASE
• CHILDBIRTH UNIVERSALLY CELEBRATED
• FOR SOME EXPERIENCE OF CHILDBIRTH IS NOT JOYFUL, BUT DISAPPOINTMENT WITH FATAL OUTCOME
• EXACT NO OF WOMEN DYING EACH YEAR FROM PREGNANCY AND CHILDBIRTH COMPLICATIONS ARE UNKNOWN
INTRODUCTION 2

• MOST MOTHERS THAT DIE ARE POOR, LIVE IN REMOTE RURAL AREAS, DEATH ACCORDED LITTLE IMPORTANCE

• WORSE STILL IN MOST DEVELOPING COUNTRIES WHERE MATERNAL MORTALITY IS HIGHEST, MATERNAL DEATHS ARE RARELY RECORDED AND WHEN THEY ARE, THE CAUSES OF DEATH ARE USUALLY UNKNOWN
PATTERN OF MM

• GLOBALLY OVER ½ MILLION WOMEN DIE YEARLY DURING CHILDBIRTH (524,000)
• APPROXIMATELY 99% ARE FROM DEVELOPING COUNTRIES
• 1/2 OF THESE DEATHS OCCURRED IN ASIA,
• REMAINING ABOUT 150,000
• OCCUR IN AFRICA
• IN NIGERIA > 54,000 MATERNAL DEATHS OCCUR YEARLY (50,000 A DECADE AGO)
MATERNAL MORTALITY RATES

- DEVELOPING COUNTRIES MMR = 100-300 / 100,000; NIGERIA RECENT FIGURE = (800-1100)/100000 IN CERTAIN PARTS OF NIGERIA

- 10% OF THE WORLD MATERNAL MORTALITY CASES

- < 60% OF PREGNANT WOMEN IN NIGERIA HAVE ACCESS TO ANTE NATAL CARE

- < 50% OF WOMEN OF REPRODUCTIVE AGE HAVE ACCESS TO FAMILY PLANNING SERVICES

- DEVELOPED COUNTRIES MMR = 7-15 / 100000
MILLENIUM DEVELOPMENT GOALS

• WHAT IS MILLENIUM DEVELOPMENT GOALS (MGD)

• COMMITMENT ADOPTED BY 189 MEMBER-STATES OF UN AT MILLENIUM SUMMIT; SEPT. 2000
WHAT ARE MDGs

1. POVERTY AND HUNGER ERADICATION
2. ACHIEVING UNIVERSAL PRIMARY EDUCATION
3. PROMOTING GENDER EQUALITY AND EMPOWERING WOMEN
4. REDUCE CHILD MORTALITY
5. IMPROVE MATERNAL HEALTH (REDUCE MM)
6. COMBATING HIV/MALARIA AND OTHER DISEASES
7. ENSURING ENVIRONMENTAL SUSTAINABILITY
8. DEVELOP GLOBAL PARTNERSHIP FOR DEVELOPMENT
MDGs AND MM CONNECTION

• WHILE 2015 WAS SET DATE FOR ACHIEVEMENT

• IMPLEMENTATION ADVICE WAS SOUGHT BY UN SECRETARY GENERAL FROM OVER 250 EXPERTS AT 2002 UN MILLINEUM PROJECT

• THEIR COMMUNIQUE WAS REFLECTED IN 2005 UN WORLD POPULATION REPORT
MDGs, MM, CONNECTION 2

• ALTHOUGH GENDER EQUALITY IS RECOGNISED AS HUMAN RIGHT AND KEY TO SUCCESS OF OTHER 7 GOALS OF MDGs
• THE GOALS ASSOCIATE GENDER EQUALITY WITH WOMEN EMPOWEMENT FOR AN ESSENTIAL SUSTAINABLE DEVELOPMENT TO ERADICATE POVERTY, HUNGER AND DISEASES
• UNFORTUNATELY REPRODUCTIVE AND SEXUAL HEALTH WERE NOT EXPLICITLY ARTICULATED- A CRITICAL OMISSION
MDGs, MM, MILESTONES;

1. INSPITE OF POOR ARTICULATION OF REPRODUCTIVE AND SEXUAL HEALTH (MDGs5)
2. THERE ARE FEW MILESTONES THAT NEEDS RECOGNITION FOR THE EFFORTS OF THE UN.
3. A QUICK COUNT DOWN FROM 2005 REVEALED THE FOLLOWING ACTIVITIES
4. 10TH YEAR ANNIVERSARY OF 4TH WORLD CONFERENCE ON WOMEN (1995)
5. 30TH ANNIVERSARY OF 1ST WORLD CONFERENCE ON WOMEN (1975)
UN EFFORTS ON MDGs

1. 10TH YEAR REVIEW OF WORLD PROGRAM OF ACTION FOR YOUTH TO THE YEAR 2000-1995

2. APPROXIMATELY 10TH YEAR ANNIVERSARY OF 1994 INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) THAT REAFFIRM GENDER EQUALITY AND REPRODUCTIVE HEALTH RIGHTS AS CORNERSTONE OF SUSTAINABLE DEVELOPMENT

3. 60TH ANNIVERSARY OF 1945 UN. CHARTER EN-SHRINING THE EQUAL RIGHTS OF MEN AND WOMEN
GENDER EQUALITY AND REPRODUCTIVE HEALTH

• WHILE THE PROUDEST ACHIEVEMENT OF 20TH CENTURY IS ESTABLISHMENT OF INTERNATIONAL HUMAN RIGHT SYSTEM AFFIRMING EQUAL RIGHTS FOR ALL

• AN INVESTMENT ON EQUAL HUMAN AND REPRODUCTIVE HEALTH RIGHTS

• OFFER MULTIPLE REWARDS

• IT WILL ACCELERATE SOCIO-ECONOMIC PROGRESS AND PRODUCE A

• LASTING IMPACT ON FUTURE GENERATION
MDGs, MM

• (MDG5) TARGET WAS TO REDUCE MATERNAL MORTALITY BY $\frac{3}{4}$ BETWEEN 1990 AND 2015 UNFORTUNATELY RIGHT NOW THE GLOBAL RECORD ON MATERNAL DEATHS IS A DISASTER

• WORSE STILL COORDINATED EFFORTS TO LOWER THE RATIO IS STILL LACKING IN MANY DEVELOPING AREAS.
INTRODUCTION 6

• INDEED MATERNAL MORTALITY IS ON THE INCREASE IN MANY SUBSAHARIAN COUNTRIES INCLUDING NIGERIA

• SURPRISINGLY UNLIKE NATURAL DISASTERS DEATH OF WOMEN AND CHILDREN ARE MOSTLY PREVENTABLE
ESTIMATES OF PHYSICIANS WORLD WIDE

• PHYSICIANS PER 100,000 POPULATION

• DEVELOPED COUNTRIES 100+

• DEVELOPING COUNTRIES 3
  – URBAN 50-100
  – RURAL 1-2
WHAT IS MATERNAL MORTALITY

1. DEATH OF A WOMAN WHILE PREGNANT OR WITHIN 42 DAYS OF TERMINATION OF THE PREGNANCY,

2. IRRESPECTIVE OF THE DURATION OR SITE OF THE PREGNANCY

3. FROM ANY CAUSE RELATED TO THE PREGNANCY, OR AGGREGATED BY THE PREGNANCY ITSELF OR ITS MANAGEMENT.
CLASSIFICATIONS OF MATERNAL MORTALITY

1. DIRECT CAUSES FROM COMPLICATIONS OF PREGNANCY, DELIVERY OR THEIR MANAGEMENT e.g. HEAMORRHAGE, INFECTION TOXEMIA, OBSTRUCTED LABOR AND INDUCED ABORTION

2. INDIRECT CAUSES ; MEDICAL CONDITIONS AGGREVATED BY PREGNANCY OR DELIVERY E.G. HEART DISEASES, HYPERTENSION, DIABETES HEPATITIS

3. UNRELATED CAUSES e.g. DEATH FROM ACCIDENTS,
FACTORS IDENTIFIED IN MATERNAL MORTALITY

- CATEGORISED INTO FOUR

1. REPRODUCTIVE FACTORS
2. OBSTETRIC COMPLICATIONS
3. HEALTH SERVICE FACTORS
4. SOCIO ECONOMIC FACTORS
REPRODUCTIVE FACTORS

1. MATERNAL AGE
   1. AGE 10-14 FIVE TIMES HIGHER THAN 20-24
   2. AGE 15-19 HAS TWO TIMES HIGHER THAN AGE 20-24

2. PARITY HIGHER PARITY MORE DANGEROUS, PARITY 5\textsuperscript{TH} TO 9\textsuperscript{TH} ARE AT 43\% MORE LIKELY TO DIE, HIGHEST LEVEL FOR WOMEN IN THEIR FIRST BIRTH

3. UNWANTED PREGNANCY PROPORTION OF WOMEN SAYING THEY DON’T WANT MORE CHILDREN RISES SHARPLY WITH AGE AND PARITY
OBSTETRIC COMPLICATIONS

1. HEMMORRHAGE
   SPONTANEOUS ABORTION, ECTOPIC, ANTEPARTUM, POSTPARTUM MULTIPLE PREGNANCY
   PUEPERAL INFECTION
   TOXEMIA
   OBSTRUCTED LABOR
   INDUCED ABORTION
HEALTH SERVICE FACTORS

• LACK OF ACESS TO MATERNITY SERVICES
• POOR MEDICAL CARE
• INADEQUATE TRAINED PERSONNEL
• LACK OF ESSENTIAL SUPPLIES ; DRUGS, INSTRUMENTS.
SOCIAL CULTURAL FACTORS

• SOME OPERATE BEFORE OR AFTER ARRIVAL

• ALL NEGATE WHATEVER REMEDIES

  1. STATUS OF WOMEN
     1. LOW STATUS, GENDER DISCRIMINATION
     2. UNEQUAL OPPORTUNITY FOR NUTRITION, HEALTH, EDUCATION
SOCIAL CULTURAL FACTORS 2

1. CULTURAL PRACTICE
   1. CULTURAL ACCEPTANCE OF LARGE FAMILY AND PRONATALISTS
   2. SOCIAL STATUS AND NO. OF CHILDREN
   3. TRADITIONAL PREFERENCE FOR BOYS
   4. CELEBRATION AFTER THE BIRTH OF THE TENTH CHILD
   5. TRADITIONAL FOOD TABOOS (FORBIDEN PROTEINOUS FOOD)
SOCIO CULTURAL FACTORS

1. POLYGAMOUS MARRIAGE ENCOURAGES COMPETITION FOR MORE CHILDREN OVER STRETCHED RESOURCES AND DEPRIVATION

2. REQUIREMENT OF PERMISSION TO VISIT HEALTH INSTITUTION

3. CULTURAL BELIEVE THAT A WOMAN IN LABOR MUST ENDURE SUFFERING (KUNYA)
SOCIAL CULTURAL FACTOR 3

1. TEENAGE PREGNANCY
   1. CULTURAL PRACTICE IN MANY DEVELOPING NATIONS
   2. PHYSICAL IMMATUREITY
   3. HIGH PARITY
   4. HIGH FERTILITY RATE
TEENAGERS AND MM

1. HEAVY WORK LOAD

   1. LOOK AFTER YOUNG SIBLINGS
   2. HOUSE CLEANING
   3. HAWKING
   4. COOKING
   5. FETCHING WATER
   6. GATHERING FIRE WOOD
SOCIO CULTURAL FACTORS

1. IN ADDITION
   1. DO OTHER DOMESTIC DUTIES
   2. TRADING
   3. FARMING
   4. WORKING
   5. DOING HEAVY WORK EVEN WHEN PREGNANT
      1. EFFECT OF ALL THESE; OVERWORK, TIRED, MALNOURISHED
SOCIO CULTURAL FACTORS

• RELIGION
  – CERTAIN RELIGION DON’T ACCEPT BLOOD TRANSFUSION
  – PRACTICE OF PURDAH MAY ISOLATE WOMEN ENCOURAGE SUBJUGATION AND OVER DEPENDENCE ON MAN
  – SOME RELIGION ENCOURAGES FATALISM ATTRIBUTING ALL MISFORTUNE TO ALMIGHTY MAKING THEM UNNECESSARILY RESIGNING TO FATE OR ENCOURAGE INSTEAD OF TAKING POSITIVE STEPS TO HELP THEMSELVES
RELIGIOUS; CULTURE.

– SOME PRAYER HOUSES HAVE BEEN CONVERTED TO ALL PURPOSE HEALING AND MATERNITY CENTER IN ATTEMPT AT EXPLOITING FOLLOWERS.

– HARMFUL TRADITIONAL PRACTICES: FEMALE GENITAL MUTILATION , FEMALE CIRCUMCISISON

– VERY HOT BATH AT DELIVERY BELIEVE BY SOME TO PREVENT ILL HEALTH
ATTITUDINAL ISSUES

1. SURGICAL AVERSION TO SURGICAL DELIVERIES

2. UNFRIENDLY AND UNCOMPASSIONATE ATTITUDE OF HEALTH WORKERS CREATES A SOCIAL AND PSYCHOLOGICAL DISTANCE BETWEEN THE POPULATION AND THE HEALTH INSTITUTION LIMITING ACCESSIBILITY
ENVIROMENTAL INFRASTRUCTURE

1. POOR INFRASTRUCTURAL DEVELOPMENT
2. BAD ROADS
3. TRANSPORTATION
ECONOMIC

• MM LINKED WITH ECONOMIC STATUS OF WOMEN
• LACK OF ACCESS TO WEALTH AND RESOURCES
• DIFFICULTY IN SECURING GAINING EMPLOYMENT
• MONEY THEY MAKE IS SPENT ON THE FAMILY RATHER THAN THEMSELVES
• GLOBAL ECONOMIC DOWNTURN COMPOUNDED THE PLIGHT OF THE MASSES
• COST OF MEDICAL ESCALATED AND UNAVOIDABLE

• GOVERNMENT UNDER FUNDING OF HEALTH (WHO 5% BUT MOST NATIONS 1.5-4%)
PREVENTION

1. FAMILY PLANNING SERVICES
2. PRENATAL CARE WITH REFERAL SERVICES
3. IMPROVEMENT ON EMERGENCY CARE FOR HEMORRHAGE, PUEPERAL INFECTION, TOXEMIA, OBSTRUCTED LABOR, INDUCED ABORTION
4. IMPROVEMENT ON THE EXISTING HEALTH CARE INFRASTRUCTURE e.g. COMMUNITY HEALTH WORKERS AND TBAS, RURAL HEALTH CENTER AND MATERNITY UNITS,
5. REFERRAL HOSPITALS
ESSENTIAL FUNCTION OF FIRST REFERRAL

1. FACILITIES FOR SURGICAL PROCEDURES
2. ANESTHESIA
3. BLOOD REPLACEMENT
4. MANUAL PROCEDURE
5. FAMILY PLANNING
6. MANAGEMENT OF WOMEN AT HIGH RISK
SUPPORTIVE FUNCTIONS AT FIRST REFERRAL CENTER

1. MATERNITY WAITING HOME
2. VILLAGE TRANSPORT
3. COMMUNITY EDUCATION
CONCLUSION

1. WOMEN DON’T NEED TO DIE IN PREGNANCY AND CHILD BIRTH
2. ALL WOMEN IRRESPECTIVE WHERE THEY ARE MUST HAVE ASSISTANCE DURING CHILD BIRTH
3. IMPROVE SKILL OF COMMUNITY HEALTH WORKERS
4. ADEQUATE STAFF AND EQUIPED FACILITIES
CONCLUSION

• ACHIEVING A DECLINE IN MATERNAL MORTALITY IS NOT A MATTER OF CHARITY, IT IS BOTH AN ETHICAL OBLIGATION AND COLLECTIVE RESPONSIBILITY

• THEREFORE TO MEET THE MDG 5 OF REDUCING MATERNAL MORTALITY BY $\frac{3}{4}$ AT THE END OF 2015, IT REQUIRES FURTHERING HUMAN DEVELOPMENT BY EMPOWERING THE POOR, ESPECIALLY WOMEN; MARGINALISED POPULATION; WHO ARE DOUBLY OR TRIPLY CONSIDERED NOT TO HAVE THEIR OWN RIGHTS
CONCLUSION

• NO OTHER AREAS OF HEALTH PRESENTS SUCH A LARGE DISPARITIES BETWEEN RICH AND POOR, WITHIN AND AROUND THE COUNTRY AND NO OTHER AREA OF HEALTH SO CLEARLY DEMONSTRATES THE IMPACTS OF GENDER INEQUALITY ON WOMEN’S LIVE
CONCLUSION

• IT IS OBVIOUS THAT THE SHOCKING MATERNAL MORTALITY IN NIGERIA CAN NOT BE EXPLAINED BY POOR ANTE NATAL CARE BUT IT IS MULTIDIMENSIONAL PROBLEM WITH NO SIMPLE SOLUTION
MATERNAL MORTALITY IN NIGERIA

- FOCUS SHOULD BE DIRECTED
- INADEQUATE EMERGENCY OBSTETRIC CARE
- EDUCATION
- WOMEN LOW STATUS
- RELIGIOUS FACTORS
- TRADITIONAL CUSTOMS
- NOT A GREAT POLITICAL INTEREST
KEY STEPS TO REDUCE MM

1. POLITICAL WILL
2. UNIVERSAL AVAILABILITY OF EMERGENCY OBSTETRIC KITS
3. TRAINING AND RETRAINING OF HEALTH CARE PROVIDERS
4. PRIORITY FOR EDUCATION OF WOMEN
CONCLUDING REMARK

• Maternal mortality in Nigeria continued to increase

• lack of basic essential obstetric care facilities,

• survey of health facilities

• 12 selected states conducted by UNFPA and FGN (2003) revealed.
CONCLUDING REMARK

• the country lacks necessary obstetric care facilities.
  The survey conducted
• Abia, Cross River, Edo, Imo, Lagos and Ondo in southern part
• Borno, Katsina, Kogi, Niger, Sokoto and Taraba in northern part
CONCLUDING REMARK

• Problems
• shortage of staff,
• shortage of drugs and supplies,
• high cost of drugs and services,
• long waiting time,
• hostile staff attitudes,
• demand for financial inducements by health workers
• coercion into running laboratory tests such as HIV screening before treatment.
CONCLUDING REMARK

• The study also showed that apart from critical shortage of skilled attendants, a considerable proportion of facilities lack equipment, with noticeable improvement in private centres.
CONCLUDING REMARK

- 13 percent of the estimated annual births for the 12 states took place in health centres,
- traditional birth attendants
- orthodox healthcare practitioners.

"Reasons include the more flexible mode of payment, the caring nature of traditional birth attendants,
- preference for delivering in spiritual homes."
CONCLUDING REMARK

- Ruptured uterus worst case contributing to maternal death rate,
- haemorrhage ectopic pregnancy,
- postpartum sepsis,
- abortion
- transportation problem.

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RECOMMENDATIONS

• upgrading of health workers
• essential obstetric centres,
• strengthening the operational capacity of health workers for quality services,
• increased policy and advocacy
• continuous monitoring of obstetric centres.
• strengthening of public-private partnership, planning and implementation of appropriately designed
• behavioural change
• communication activities