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SAFE MOTHERHOOD AND NEWBORN HEALTH

Women are still deprived of access to lifesaving essential and emergency obstetric care

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ABSTRACT

Two decades have passed since the global community agreed in Nairobi to the Safe Motherhood Initiative to reduce maternal deaths. However, every year 536 000 pregnant women are dying. There is no ambiguity about why most of these women are dying. These tragedies are avoidable if women have timely access to quality essential obstetric and emergency care. Rural and poor women are mostly excluded from accessing skilled and emergency care. Quality facility-based care is the best option to reduce maternal mortality. Scaling up essential interventions and services—particularly for those who are excluded—is a substantial and challenging undertaking. We need to challenge our policy makers and program managers to refocus program content; to shift focus from development of new technologies toward development of viable organizational strategies to provide access to essential and emergency obstetric care 24 hours a day 7 days a week, and account for every birth and every death.

1. Background

The global community came together 20 years ago in Nairobi, Kenya, to launch the Safe Motherhood Initiative and highlight the shameful situation of maternal health and survival—the most striking inequity in public health. This global initiative was launched to generate political will, identify effective interventions, and to mobilize resources that would rectify a horrifying injustice and violation of women's right to life. Yet, each year 3.3 million babies are stillborn and more than 4 million newborns die within 28 days of coming into the world. There are 536 000, often sudden, unpredicted deaths of women during pregnancy, during childbirth, or after the baby has been born—leaving behind devastated families, often pushed into poverty because of the cost of health care that came too late or was ineffective.

The international community agreed to address the issue of maternal mortality by agreeing to Millennium Development Goal 5, to improve maternal health, with one of its boldest targets the reduction of the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 [1]. However, maternal and newborn mortalities remain the world's most neglected problems, and progress on reducing the maternal mortality ratio and newborn mortality remains very uneven and continues to stagnate in countries where the problems are most acute. At the present rate of progress, the world will fall well short of the target for reduction of maternal mortality as well as infant mortality.

2. Situation analysis

In high-income countries maternal deaths from obstructed labor are nonexistent, and universal access to simple and effective interventions to prevent and treat postpartum hemorrhage, sepsis, and hypertensive disorders of pregnancy has been ensured for many years. In low-income countries a third of all pregnant women receive no health care during pregnancy, 60% of deliveries take place outside health facilities, and only about 60% of all deliveries are attended by skilled staff. As long as effective strategies to increase attendance of skilled personnel at childbirth, provide timely lifesaving emergency obstetric care, and promote facility-based deliveries are not implemented at scale and with quality, it will be difficult to reduce maternal mortality and morbidity [2].

In some regions of the world, primarily in Sub-Saharan Africa and South Asia, women are still facing very high risks of dying during pregnancy and childbirth. This situation is an infringement of their rights. Article 12.2 of the Convention on the Elimination of All Forms of Discrimination against Women, which 185 countries have ratified to date, requires States Parties: "…ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" [3]. The causes of maternal mortality and morbidity are so clear, and effective interventions to combat them are well known—it is therefore difficult to avoid the conclusion that they have remained unaddressed for so long because of women's disadvantaged social, political, and economic status in many societies.

There is no ambiguity about why most of these women are dying. As identified by WHO 20 years ago, women are dying because they have no or limited access to health services, or because the quality of

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care is poor during pregnancy, childbirth, and in the postpartum and postnatal period, and when life-threatening complications arise [4]. They die because of hemorrhage, sepsis, hypertensive disorders, unsafe abortion, and prolonged or obstructed labor—complications that are unpredictable, but that can often be effectively managed in a responsive and functional health system that provides quality skilled care during pregnancy, childbirth, and the postpartum and postnatal periods, and can handle emergencies when they occur [5]. Yet thousands of women are deprived of this opportunity to have timely access to quality skilled care, including emergency care services. Poverty, inequity, women's low status, and societal attitudes toward women and their needs are still the underlying factors affecting women's access to healthcare services [6].

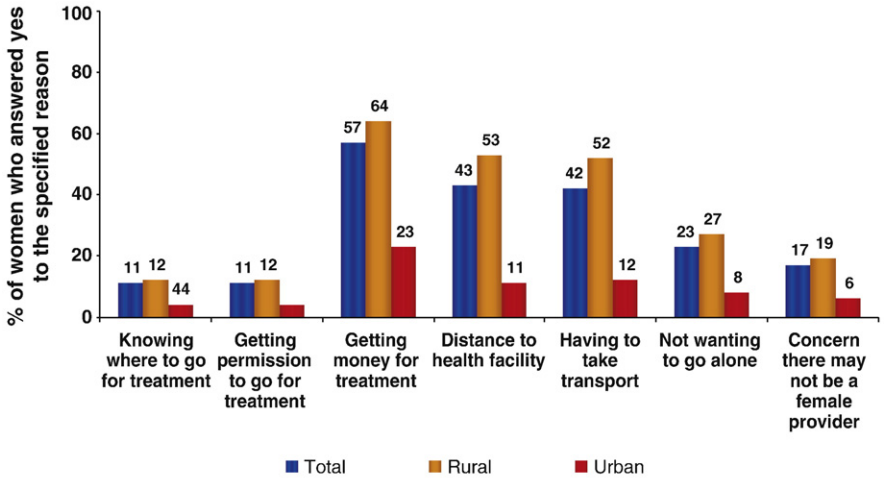
We also know that most maternal deaths occur during childbirth or the first 24 hours post partum, and most complications can not be predicted or prevented. Individual complications are quite rare, and timely diagnosis and appropriate interventions require considerable skills to prevent deaths and to avoid introducing further complications and harm. The location of women when they start labor and then deliver, who is attending them, and how quickly they can be transported to referral-level care are thus crucial factors determining access to interventions that are needed and feasible [7]. Two cost-effectiveness analyses of maternal and neonatal care packages and means of distribution have emphasized the potential of close-to-client care for normal and complicated cases—essentially encompassing basic essential obstetric care and emergency obstetric care, and finding them among the most cost-effective options [8,9]. The unpredictability, suddenness, and the short window of opportunity to save lives on the one hand, and the cost - effectiveness, organizational, and managerial feasibility of having a team of skilled workers in one place on the other hand provide us with a strong rationale to promote and provide the choice and means to all pregnant women to have quality facility-based care.

A facility equipped to provide basic emergency obstetric and newborn care offers 7 signal functions: the administration of parenteral antibiotics, oxytocic drugs, and anticonvulsants; manual removal of the placenta; removal of retained products; assisted vaginal delivery; and neonatal resuscitation. A facility capable of comprehensive emergency obstetric care will be able to provide these 7 signal functions as well as perform cesarean deliveries and blood transfusions. All women should have the right to access these emergency obstetric care services to save their lives.

3. Access, coverage, quality: The inequities

Although an increasing number of countries have succeeded in providing emergency obstetric and newborn care in recent years, the countries that began with the highest burdens of maternal and neonatal mortality and ill health made the least progress during the 1990s [10]. In some countries the situation has actually worsened, and worrying reversals in maternal and newborn mortality have taken place. Progress has slowed down and is increasingly uneven, leaving large disparities between regions and countries. Within one single country there are often striking inequities and differences between population groups, and national figures mask substantial internal variations—geographical, economic, and social [11,12]. Rural populations have less access to skilled and emergency care than urban dwellers; among urban dwellers, mortality is higher in urban slum populations; rates can vary widely by ethnicity or by wealth status, and remote areas often bear a heavy burden of deaths. Moreover, ill health among pregnant women, and particularly the occurrence of major unpredictable obstetric problems and delayed care seeking, can lead to catastrophic expenditure that may push households into poverty and further exclusion in future [13]. Unless efforts are increased radically, there is little hope of eliminating the avoidable maternal and newborn mortality in many countries.

Fifteen percent of child births are expected to have complications that require emergency obstetric care [14], and all women with complications should have access to such care. Assessments in several countries find important gaps in coverage. One barrier to accessing emergency obstetric care is the lack of facilities near rural communities. Access is also hindered by lack of money, poor transport, and distance. Even when transport is available, it requires additional cost. Aside from these geographic and financial barriers, cultural barriers are also likely to prevent people from seeking emergency help. It is vital that the health facility has an effective infrastructure, medical equipment and supplies, and qualified staff to support women seeking care. Secondary analysis of Demographic and Health Surveys from 24 countries in Africa carried out by the Making Pregnancy Safer Department of the WHO shows the main barriers to accessing a health facility (Fig. 1). The sample used in the analysis consisted of data from 226 350 women in the reference period from 2000 to 2006. Women were asked whether or not each of the factors would pose a problem in seeking care. The majority of women (57%) expressed that financial inability was the main reason for not



Source: Macro International Inc, 2008. MEASURE DHS STAT compiler. http://www.measuredhs.com, July 16 2008.Secondary analysis conducted by the WHO Department of Making Pregnancy Safer.

Fig. 1. Reasons given for not attending a health facility.