Why is the decline in maternal mortality so slow in the world?

Bernt Lindtjørn
Why do mothers die?

Medical causes:

- Bleedings
- Obstructed labour
- Infections
- Eclampsia
- Abortions

Indirect causes (Tuberculosis, HIV and Malaria)
Why do mothers die?

But, the real causes are:

Lack of institutions

Lack of trained personnel

Lack of access

(transportation)
FIGURE 1—Percentage of parturients in Sweden delivered by traditional birth attendants, licensed midwives, and in lying-in hospitals during the years 1861 through 1895.
Secular trends in maternal mortality in Sweden from 1750 to 1980

ULF HOCBERG1 & STIG WALL2

Fig. 1. Maternal mortality rates in Sweden over the period 1751–1980. The plot shows crude death rates per 100,000 live births at 5-yearly intervals.
OBJECTIVE
Use of quality delivery care during normal and complicated deliveries

INPUTS (THE FOUR PILARDS)
- Advocacy and awareness
- Social marketing
- Behavioural change communication (BCC)
- Community capacity strengthening

INPUTS (SCI ACTIVITIES)
- Danger signs
- Birth preparedness
- Emergency preparedness
- Quality delivery care
- Cost sharing system
- Microfinance
- Community link agents (CLA)
- Health seeking behaviour
- Birthing and weaning practices
- COPE* (Providers-clients)

PROCESS (MECHANISMS)
- Qualitative study
  - Health seeking behaviour
  - Birthing and weaning practices
  - Social organisation, networks, communication channels
- Local stakeholders
  - Engage credible traditional leaders, Local associations
  - Religious & political leaders
- Community link agents (CLA)
  - Close sensitisation, monitoring
- BCC interventions
  - Community workshops
  - Theatres, singers
  - Birth preparedness
- Monitoring & evaluation
  - Follow up community workshops
  - Formative supervision of CLA
  - Workshop with health workers

OUTPUTS (OUTCOMES)
- Increased knowledge, preparedness for delivery, increased utilization of maternal health services
- Ensure normality of deliveries and early detection and management of complications
- Reduction in maternal, neonatal and perinatal mortality

Citation: Global Health Action 2009. DOI: 10.3402/gha.v2i0.1947
Why is the decline in maternal mortality so slow in the world?

Concentrate on what is most important
The time is right to shift the focus of the global maternal health community to the challenges of effective implementation of services within districts.

**Panel 3: Signal functions for basic and comprehensive emergency obstetric care**

**Basic emergency obstetric care**
1. Parenteral antibiotics
2. Parenteral oxytotic drugs
3. Parenteral anticonvulsants
5. Removal of retained products
6. Assisted vaginal delivery

**Comprehensive emergency obstetric care**
All of the above plus:
7. Surgery (eg, caesarean delivery)
8. Blood transfusion
Figure 1: AMDD building blocks framework for emergency obstetric care
Reducing maternal mortality project:

- Developing small hospitals
- Equipment
- Supervision
- Training
  - Non-clinical physicians
  - Nurses
  - Midwives
  - Health extension workers
Reducing Maternal Deaths

Context: Rural mountainous area

Intervention: About 100 institutions (pop 2.5 mill people)

Multiple interventions

Learning process
## Institutions per population

<table>
<thead>
<tr>
<th>Year</th>
<th>CEmOC institutions</th>
<th>Population per institution</th>
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<tbody>
<tr>
<td>2008</td>
<td>1</td>
<td>2 100 000</td>
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<tr>
<td>2012</td>
<td>8</td>
<td>275 000</td>
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<tr>
<td>2015</td>
<td>12</td>
<td>182 000</td>
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RMM work
Areas with varying distance from hospitals, 2012

- Hospitals
- Areas within 5 kilometres
- Areas within 10 kilometres
- Areas within 20 kilometres
- Areas with >20 Kilometres
- Hawassa city
- Lake Hawassa

Distance Scale:
- 0 to 5
- 10
- 20
- 30
- 40 Kilometers
1000 deliveries / year
Maternal waiting area
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Birth registration

HEW assisted deliveries: 10.8% - 23.3%

Hospital deliveries: 6.4% - 12.5%

CS: 0.5% - 1.0%

TBA: 42% - 30% (In Gidole: 83% - 47%)
Neonatal care

In the community

BEmOC: NCU

CEmOC: NICU

Mortality:

22% => 8%
Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia

Anteneh Asefa and Delayehu Bekele

78% experienced disrespect and abuse
Box 1: Robson classification

Group 1: Nulliparous with single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

Group 2: Nulliparous with single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

Group 3: Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

Group 4: Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

Group 5: All multiparous with at least one previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation

Group 6: All nulliparous women with a single breech pregnancy

Group 7: All multiparous women with a single breech pregnancy, including women with previous uterine scars

Group 8: All women with multiple pregnancies, including women with previous uterine scars

Group 9: All women with a single pregnancy with a transverse or oblique lie, including women with previous uterine scars

Group 10: All women with a single cephalic pregnancy <37 weeks gestation, including women with previous scars
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<td><strong>&lt; 10 %</strong></td>
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<tr>
<td>Associated with higher maternal and newborn deaths</td>
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<tr>
<td><strong>10-15%</strong></td>
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<tr>
<td>Good outcome (decreased maternal and newborn deaths)</td>
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<td><strong>16-30%</strong></td>
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<tr>
<td>No additional benefit</td>
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<tr>
<td><strong>&gt; 30%</strong></td>
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<td>No additional benefit</td>
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Socio-economic status and CS rates Africa

The poor have extremely low access to CS

Rural rich have no advantage compared to urban poor
60% of all deliveries end in a CS
Corruption
Hva er viktig?

Gjøre helsetjenestene tilgjengelige for alle!