

Listening to Women's Voice in the Reduction of Maternal and Child Morbidity and Mortality

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Outline of Discussion

- Introduction
- Overview of maternal and child morbidity and mortality
- Global and local actions to reduce maternal and child morbidity and mortality
- Experiences and expectations of women on issues of maternal and child health
- The gaps between what is being done and what the women desire to be done
- Global road map post 2015 (2016-2030)
- With the global initiative, have the women been heard ?
- Challenge to Midwives

Introduction

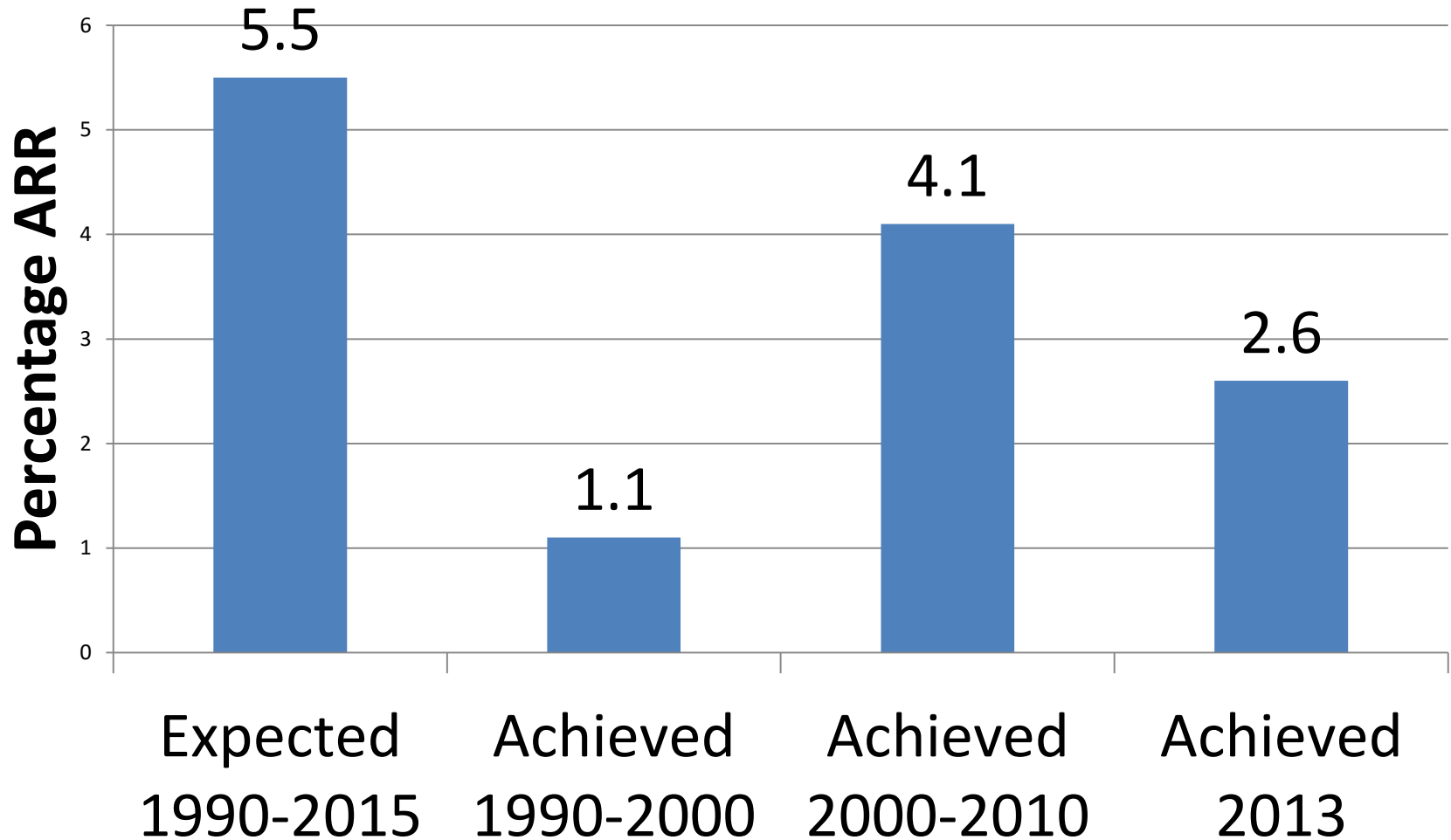
- Maternal and newborn health are related
- Most of the deaths are preventable and avoidable
- Almost all maternal deaths occur in under resourced countries and among the most vulnerable
- Reduction Rate targets have been set over the years and monitored
- The accelerated progress recorded between 2000 and 2010 was attributed to commitment and effort demonstrated by countries
- While 19 countries met and surpassed the targets, some countries never met the target and the MMR is worsening

Overview of maternal and child morbidity and mortality

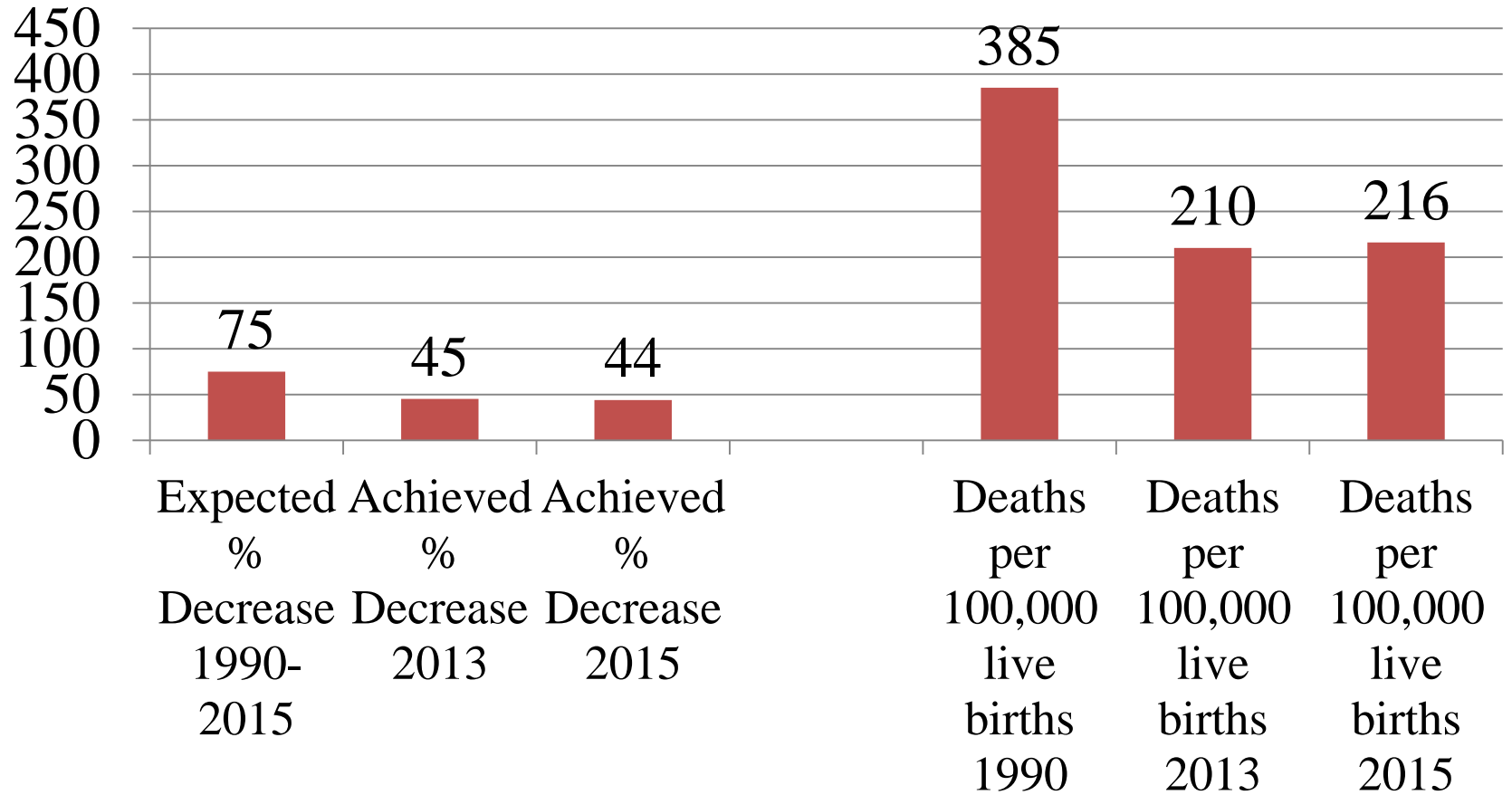
Maternal mortality and morbidity (Global)

- 43% reduction in **annual number** of maternal deaths from approximately **532 000** in 1990 to an estimated **303 000** in 2015
- **830** women die **daily** from preventable causes
- **lifetime risk** of a maternal death fell considerably from **1 in 73** to **1 in 180** (**1 in 4900** in developed countries)
- The maternal mortality ratio in **developing countries** in 2015 is **239** per 100 000 live births versus **12** per 100 000 live births in **developed countries**
- As of 2015, the two regions with **highest MMR** are **sub-Saharan Africa** and **Oceania**

Expected and Achieved MMR Annual Rate of Reduction (ARR) 1990-2015



Expected and Achieved Decrease in Maternal Mortality Rate 1990-2015



Maternal mortality and morbidity (**Nigeria**)

- Far below global average, taking a downward turn
- Nigeria and India account for over 1/3 of all maternal deaths worldwide in 2015
- Maternal mortality worsened from estimated **576** in **2013** to **814** maternal deaths per 100,000 live births in Nigeria in **2015** (about **50%** due to **PPH** and **pre-eclampsia**)
- In **2015**, approximately **58000** maternal deaths, **19%** of global maternal mortality in 2015
- As there are regional variations, so are there in-country variations
- Worst in **six states** in **Northern Nigeria** - **More than 100** women die **daily** across Northern Nigeria
- **Lifetime risk** of maternal death in Nigeria was **1 in 30** in **2013** and **1 in 23** in **2015**

Maternal Morbidity

- Maternal morbidity - **any health condition attributed to or complicating pregnancy, childbirth or following pregnancy that has a negative impact on the woman's well-being or functioning**
- **For every maternal death, 20–30 more women experience acute or chronic pregnancy-related morbidities**, such as obstetric fistula or depression, which **impair their functioning and quality of life, sometimes permanently**

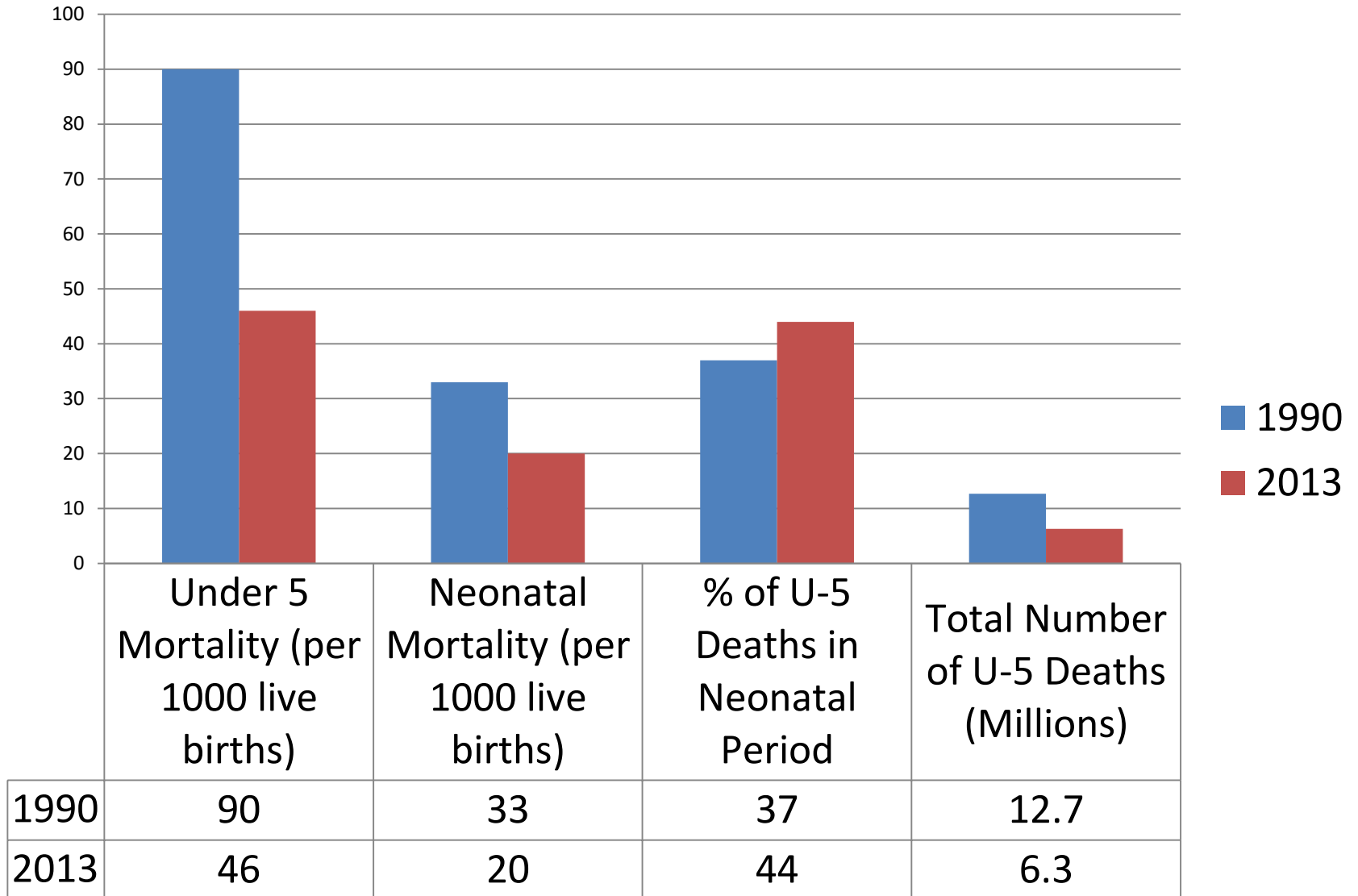
Causes of maternal deaths

- Haemorrhage, Infections, High blood pressure during pregnancy (pre-eclampsia and eclampsia), Unsafe abortion, Others caused by or associated with diseases such as malaria, and AIDS during pregnancy

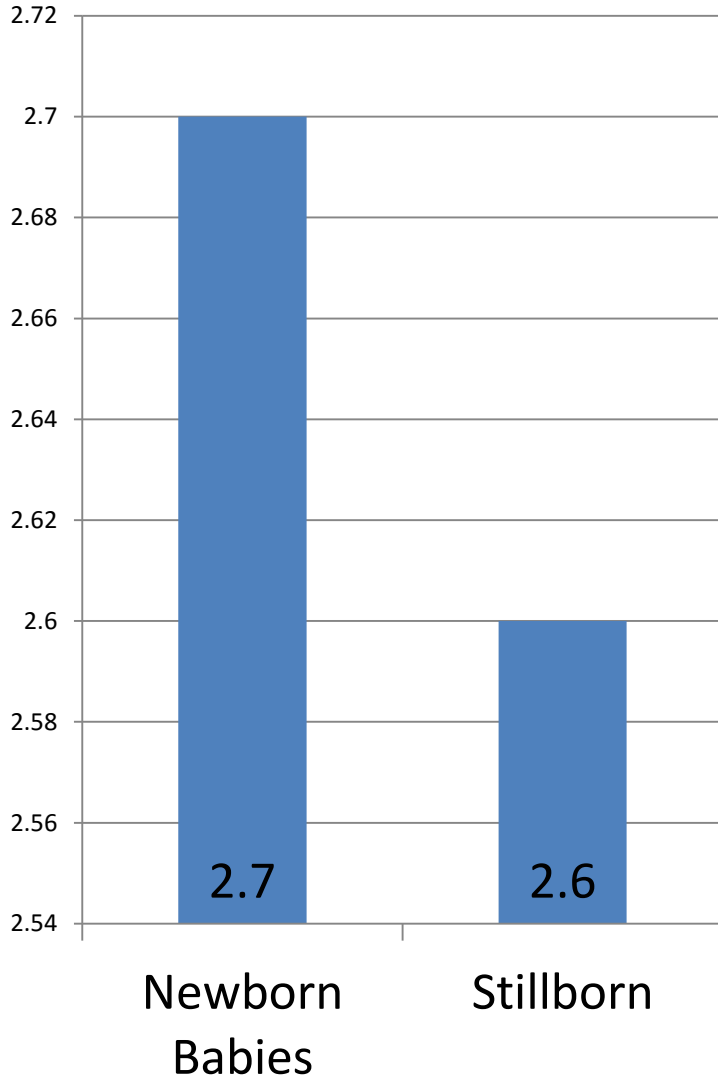
Where and why maternal deaths occur

1. Rural, Underdeveloped
2. Young adolescents <15
3. Breakdown of health system; Inadequate services
4. Inequities in access to health services
5. Low numbers of skilled health workers (midwife, doctor or trained nurse)
6. Poverty
7. Distance
8. Lack of information / lack of education
9. Cultural practices
10. Poor antenatal, intra partum and post partum attendance
11. Emergent humanitarian settings and situations of conflict, post-conflict and disaster

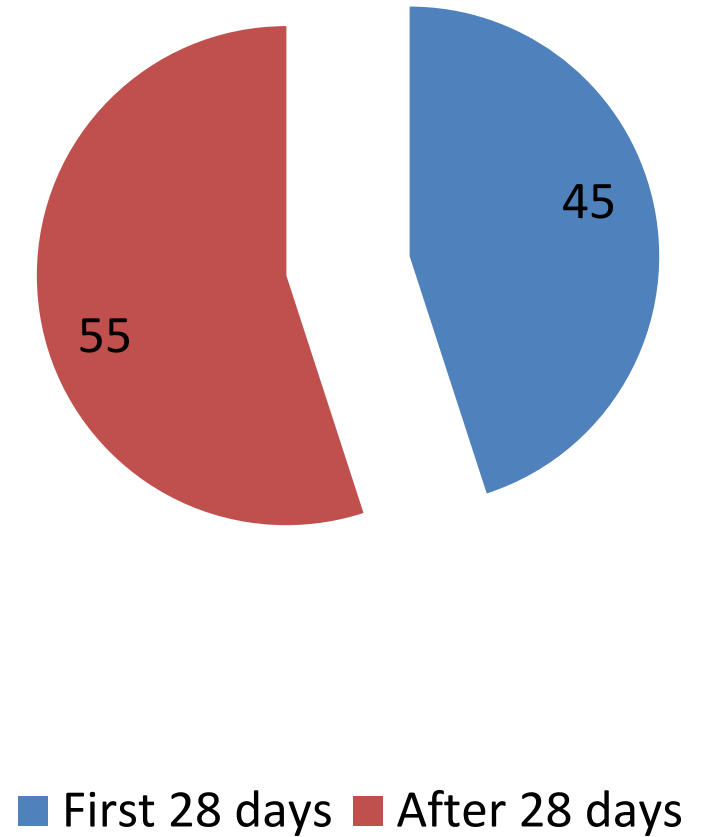
Pattern of U-5 Mortality



Newborn Deaths & Stillborn in 2015 (Millions)



Percentage of Under 5 Deaths

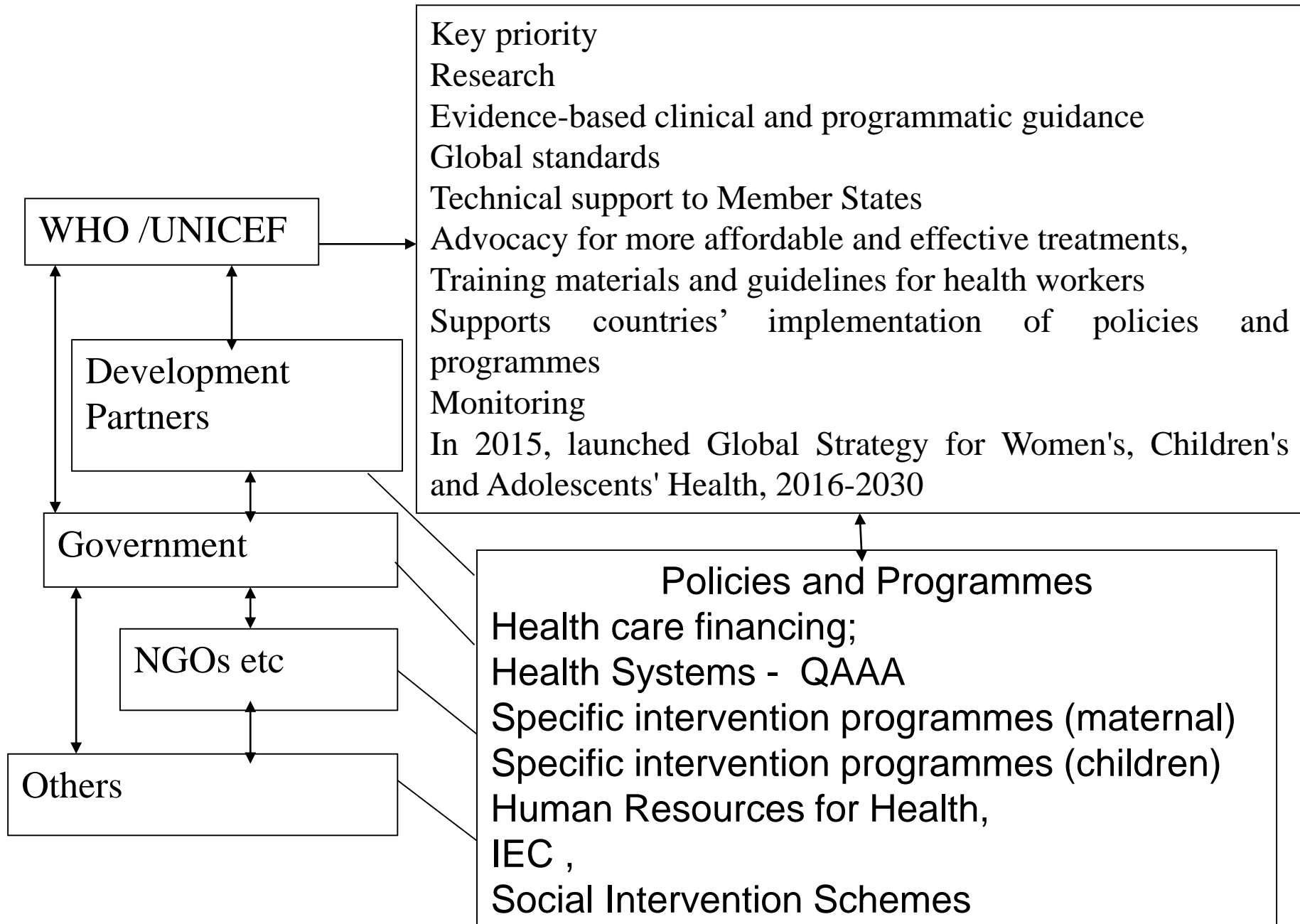


Child Mortality (Under-5 mortality)

- In 2015, 5.9 million children under the age of 5 years died
- Annually, nearly **45%** of all under 5 child deaths are **babies in their first 28 days of life or the neonatal period.**
- **75%** of all **newborn deaths** occur in the **first week** of life; and **25% to 45%** occur within the **first 24 hours.**
- All regions **except Sub-Saharan Africa and Oceania** have **reduced** the rate by **52 percent or more**

- U-5 mortality rate in **sub-Saharan Africa** is 92 deaths per 1,000 live births more than **15 times the average of developed** countries and children are **14 times more likely to die before the age of 5** than children in developed regions.
- **Leading causes of death in children under 5** years are preterm birth complications, pneumonia, birth asphyxia, diarrhoea and malaria. About **45%** of all child deaths are linked to **malnutrition**.

- About **half** of under-five deaths occur **in only five countries**: India, **Nigeria**, Pakistan, Democratic Republic of the Congo and China.
- Infant and under-5 mortality rates are **69** and **128** deaths per 1,000 live births, respectively.
- At these mortality levels, **one in every 15** Nigerian children dies before reaching age 1, and **one in every eight** do not survive to their fifth birthday.



Global and local actions to reduce maternal and child morbidity and mortality

Experiences and expectations of women on issues of maternal and child health

- *A woman who has no confidence in her medical treatment is unlikely to follow through with it anyway*
- Sometimes postpone care unnecessarily because of reluctance to place themselves in what they perceive to be a fearful and humiliating situation

(The Vancouver Women 's Health Collective, 1976)

- 1976, (41 years ago) the women complained and demanded better treatment
- Some of the complaints included:

- not being treated as equals
- insensitive to the needs
- kept waiting without explanation
- placed in vulnerable position without due attention
- not given a choice as to whether or not to be draped
- not informed of what is being performed on them
- sit between their legs, chatting about unrelated issues e.g. weather ; felt depersonalized
- wanted information to become active participants own health care; information often denied told 'it's too complicated to be understood
- often not open to a thorough discussion with the assumption is that the 'doctor knows best'

(The Vancouver Women 's Health Collective, 1976)

Today, women who use facilities & women who do not use facilities are still talking

- High and inconsistent cost of services (Obinna, 2016)
- No drugs
- No commodities
- No personnel
- Facilities far and not easy to reach
- No information about regular / outreach programmes
- Appreciate information in own language through mobile phone (Ejiofor,2014)

- Hospital delivery safer and preferred but need:
 - More skilled care providers; Privacy
 - Pain relief; Companionship
 - Participation in decision making about own care
 - More information
 - Good communication between providers, woman and family
- (Raven, et al, 2015)

Akin-Otiko & Bhengu (2012), observed that:

- Midwives were women's preferred source of information; could clarify issues of interest directly
- Information was more about child care and less about maternal care and danger signs

- Facility delivery is for women with complications
- Distance and cost not the problem, still pay TBAs in cash and kind and services in facility is free
- Frustrated with services of TBAs, but always there
- If services QAAA and good interpersonal relationship will use facility
- Harsh words to encourage compliance discouraging, will rather deliver at home than face outburst of an annoyed midwife; Want good midwives
- Enjoyed listening to midwives and believe them
- Selective utilization of info due to lack of resources to comply and whether or not considered important
- Midwives should look up to God who alone can reward them

Study about women who survived obstetric complications revealed:

- Tertiary care hospitals are frequently perceived as places where women go to die,
- Importance of information, good communication and attitudes, and availability of human (i.e., more doctors) and physical resources (i.e., more beds, water) at the facility.
- In spite of the important concerns about the quality of care, most women in the study were willing and preferred to deliver at the tertiary facility in the future. (Tunçalp, et al, 2012)

The gaps between what is being done and what the women desire to be done

- *“We know what we have to do to save the lives of women and girls everywhere. Needless deaths of women, newborns and children must stop. We must do **more** and we must do **better** because every action counts and every life counts,”*

Graca Machel, Chair, The Partnership for Maternal, Newborn & Child Health (Every Woman Every Child, 2015)

Global road map for post 2015 agenda (2016-2030)

End all preventable deaths of women, children and adolescents ... objectives along three axes:

- 1) Survive (end preventable deaths);
- 2) Thrive (ensure health and well-being); and
- 3) Transform (expand enabling environments).

As part of the Global Strategy and goal of Ending Preventable Maternal Mortality (EPMM) , WHO is working with partners towards five strategic objectives

Five strategic objectives for EPMM

- 1. Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care
- 2. Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care
- 3. Address all causes of maternal mortality, reproductive and maternal morbidities and related disabilities
- 4. Strengthen health systems to respond to the needs and priorities of women and girls
- 5. Ensure accountability to improve quality of care and equity
Planning for accountability in the post-2015 maternal health strategy emphasizes two equally important dimensions

- maternal mortality less than 70 per 100 000 live births,
 - neonatal mortality at least as low as 12 per 1000 live births
 - under-5 mortality at least as low as 25 per 1000 live births
 - ending major global epidemics (HIV, tuberculosis and malaria);
 - meeting needs e.g. essential RMNCAH services
 - adequate nutrition, clean water and environments;
 - ending extreme poverty
 - providing universal primary and secondary education
 - ending harmful practices and violence against women and girls
- (Every Woman Every Child, 2016)

- Countries contribute to global targets
- Country target of MMR: at least two thirds of their 2010 baseline level
- No country should have an MMR greater than 140/100 000 live births (a number twice the global target) by 2030
- **Nigeria's** target **300** maternal mortality rate in **2018** and below **100** ratio by the year **2030**
- Country-level workforce management is critical
 - recruitment, distribution and retention
 - supportive supervision
 - task shifting

- **87%** of **essential** maternal and newborn health care services can be provided by **midwives**, educated, regulated to international standards, working in well-equipped enabling environments
- Universal coverage of **essential** MNCH & family planning within midwifery scope of practice could avert **83%** of all maternal and neonatal deaths and stillbirths.

Core principle for MNCH lifelong access to health care

- a **continuum of care for the mother** starting from long before pregnancy (during childhood and adolescence) through pregnancy and childbirth
 - **continuum** of care for the **newborn care for the new life**
 - Delivered in the **home** and **community, health clinics** and **hospitals**
- WHO and partners

With the global initiative, have the women been heard ?

- **Appropriate action** that yields **desired result** is the evidence of **good listening** and **genuine sensitivity** to the unacceptably high morbidity and mortality rates
- MNCH services exist within the entire health and social systems where enabling policies are dependent on the **vision** and **passion** of the group in charge of the resources and prioritization of programmes / projects
- Nigeria's focus - Universal Health Coverage (UHC)-
renovation of Primary Health Centres ... Is that it?

Challenge to Midwives

- Midwifery = With Woman
- Theme of Nurses Week 2017 = Nurses, a voice to lead achieving SDGs
- Policy on private midwifery practice
- Entrepreneurship
- Public Private Partnership (PPP)
- Making Midwifery education and practice count

Thank you for listening!!!

