



Maternal Morbidity: Neglected Dimension of Safe Motherhood

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Silent Suffering: Maternal Morbidities

in Developing Countries

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Outline

Why Focus on Maternal Morbidity?

Examples of the Range of Maternal Morbidities

Recommendations

Why Focus on Maternal Morbidity?

- 20 to 1
- Programming has given less attention to addressing maternal morbidity
- Maternal morbidity affects women, their families, communities and societies
- Analysis of global costs of maternal disability: \$6.8 billion annually (Stanton, 2010)



Outline

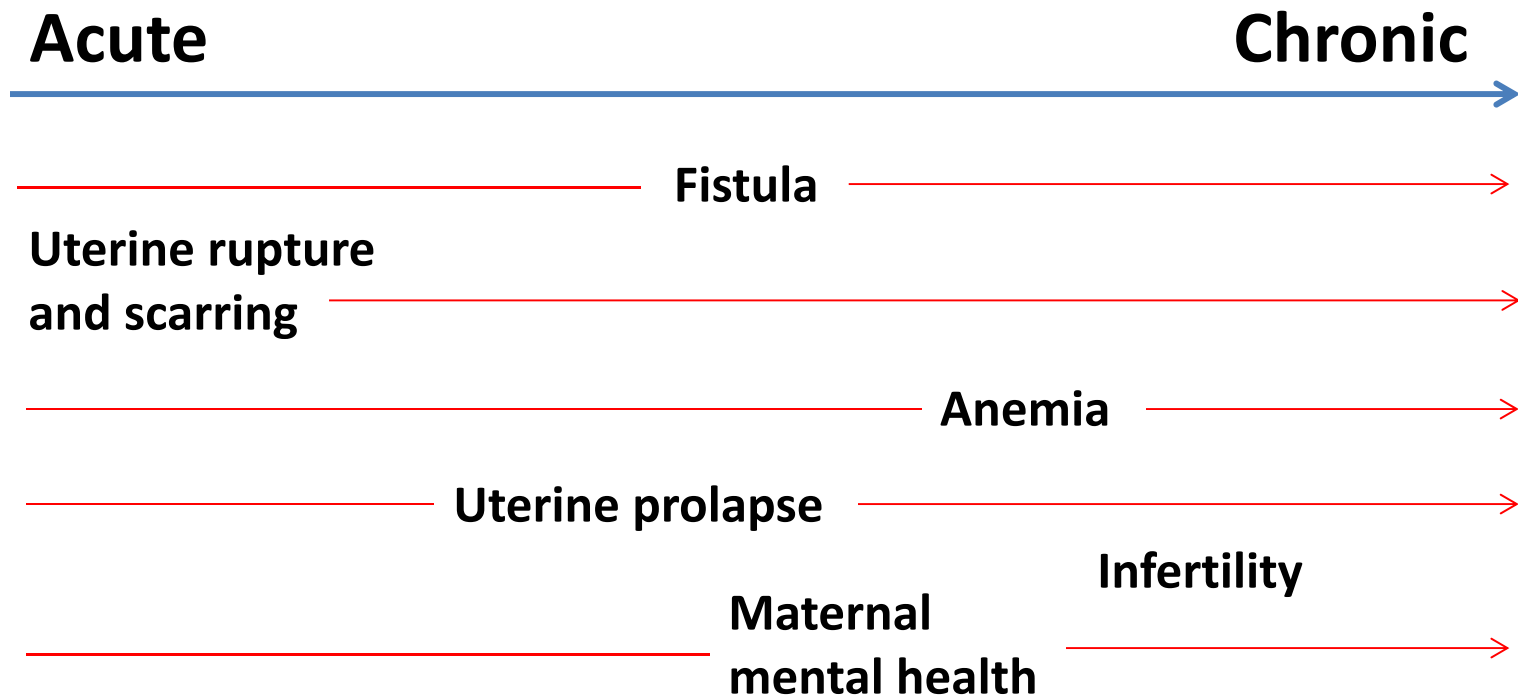
Why Focus on Maternal Morbidity?

Examples of the Range of Maternal Morbidities

Recommendations

Examples of the Range of Maternal Morbidity

Morbidities prevalent in developing countries that affect women related to pregnancy and childbearing:



Uterine Rupture

- Forcible tearing of the uterus; can result in maternal death, maternal morbidity or fetal death
- Prevalence in developed countries vary from 1 in 1,000 for scarred uteri to less than 1 in 10,000 unscarred uteri
- Rates in developing countries approximately ten times higher
- Very low incidence possible with functioning maternal health systems

Programming for Uterine Rupture



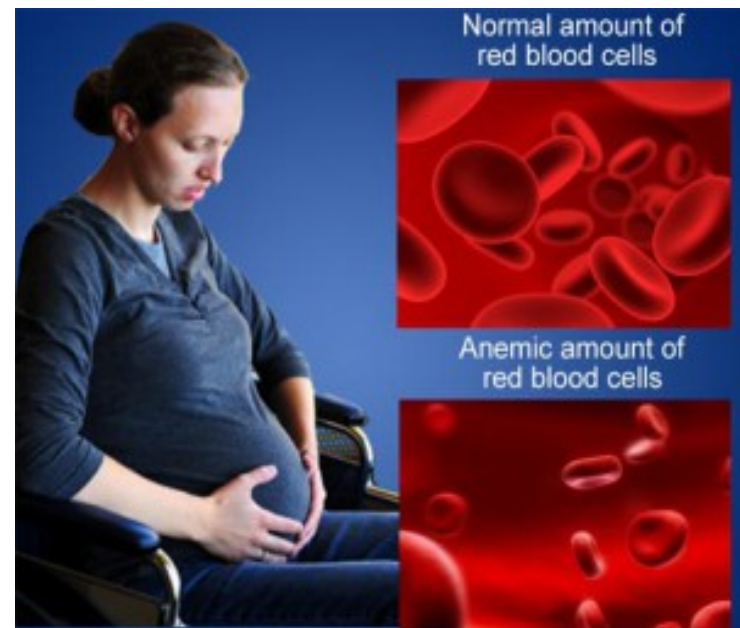
- Awareness by women of obstetric emergencies and plans to access EmOC
- Functioning referral systems

- Safe C-sections and blood transfusions
- Training to eliminate incorrect use of oxytocic drugs and fundal pressure



Anemia

- 42% of pregnant women have anemia worldwide
- Iron-deficiency anemia is most common
- Anemia exacerbates complications of pregnancy



Effects of Anemia

- Link to morbidity and mortality:
 - poor ability to withstand the adverse effects of excessive blood loss
 - increased risk of infection or maternal fatigue
- Also associated with:
 - depression
 - fatigue
 - low work productivity
 - poor pregnancy outcomes

Programming for Anemia

- Iron-folic acid supplementation
 - Thailand reduced anemia in pregnant women from 25% to 17% between 1988 and 1997



- Prevent malaria (e.g. bednets) is important

- Many countries do not meet current WHO standards for iron-folic acid supplementation and coverage remains low
- Integrated health system and community nutrition, fortification and supplementation approaches:
 - Ghana: 63% to 25%
 - Malawi: 59% to 48%
 - Senegal: 81% to 65%
 - Tanzania: 87% to 73%

Genital and Uterine Prolapse

- Global prevalence genital prolapse: estimated to be 2 to 20% in women under age 45
- Uterine prolapse - uterus slips from place into the vagina
- Trauma or difficulty at childbirth; carrying heavy loads, particularly postpartum



Effects of Uterine Prolapse

- Difficulty walking, sitting, lifting, and squatting
- Lower back pain and abdominal pain
- Painful intercourse
- Difficulty urinating and defecating

Genital and Uterine Prolapse

- Women often do not know that treatment exists and cannot afford to pay for treatment
- **Nepal** (Kumari et al., 2000)
 - 57% of those with symptoms of uterine prolapse had not had any treatment and of the 38 women advised to have an operation, only 8 did so



Programming for Uterine Prolapse

- Surgery is needed once prolapse occurs
- Prevention:
 - Prolapse check list in regular gynecological services
 - Reducing women's workload postpartum
 - Encouraging men to take over chores that involve heavy lifting

Infertility

- Various definitions of infertility: one or two years; primary and secondary
- 2002 DHS analysis of 47 countries estimated around 186 million MWRA faced infertility

“This number represents more than one-fourth of the ever-married women of reproductive age in these countries” (Rutstein and Shah, 2004: xiii).

Effects of Infertility

- Fertility highly valued in most societies; inability to have children can lead to negative social outcomes
- Infertile women face social stigma and marital instability
- **Tanzania:** (Hollos and Larsen, 2008)
 - life circumstances of infertile women were considerably worse than circumstances of women with at least one child

Programming for Infertility

- Despite severe negative consequences for women, infertility has received insufficient attention in SM and RH programs
- STIs are the most preventable cause of infertility, particularly in women
- Ethical expansion of access to assisted reproductive technologies (ART)

Maternal Mental Health

- Mental health issues following childbirth fall into three distinct conditions:
 - transient mood disturbance
 - depression (most common)
 - psychotic illness
- An estimated 20-30% of women suffer from depression in the peri-natal period in developing countries

Effects of Poor Maternal Mental Health

- Effects on the mother herself
- Adverse effects on infant and child outcomes:
 - under nutrition
 - stunting
 - problems with breastfeeding
 - behavioral problems
 - child temperament
 - childhood depression
 - cognitive and motor delays
 - low academic achievement



Programming for Maternal Mental Health

- Successful/promising interventions:
 - Social support for depressed mothers or mothers at risk of depression in Taiwan
 - Group therapy in Uganda
 - Use of existing health mechanisms in Jamaica
 - Enhancing mother-infant interactions in South Africa
 - Community health workers in Pakistan

Programming Needs for Maternal Mental Health

- Need to address:
 - Environmental stressors
 - Mental health problems among women who experience a perinatal death and near miss-complications
 - Co-morbidities (e.g. mental health and infertility; fistula)
- Programming:
 - Training for providers on psychosocial aspects of health
 - Screening for risk factors for poor mental health during perinatal care
 - Community health worker programs for pregnancy-related depression into IMCI and MCH programs



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Examples of the Range of Maternal Morbidities

Recommendations

Expand the focus of safe motherhood to explicitly include morbidity

Mortality

Morbidity/disability/Injury



- *Safe Motherhood A Review. The Safe Motherhood Initiative 1987 to 2005*
- *Countdown to 2015 Decade Report (2000-2010) Taking Stock of Maternal, Newborn and Child Survival*
- *Focus on 5 (Women Deliver)*
- *DfiD's 2010 framework for results for improving reproductive, maternal and newborn health in the developing world*

Improve data on the incidence and prevalence of maternal morbidity

- Accurate and reliable data needed for programming
- Consensus on definitions and data collection

“Limited epidemiological evidence suggests that the causal pattern of morbidity is different from the causal pattern of mortality and information on morbidity could change the way interventions are prioritized in safer motherhood” (www.cherg.org).

- Research on costs, burden of disease and economic impact of maternal morbidity
 - Study from Bangladesh
 - Ongoing research in Sri Lanka and Kenya

Link maternal mortality and morbidity outcomes and programming

- Where is there overlap and where is there not in programming for maternal mortality and maternal morbidity?



- Mexico (Hu et al., 2007) :
 - The same cost-effective interventions which would reduce maternal mortality would reduce maternal morbidity associated with some maternal complications

Increase access to facility- and community-based maternal health care

- Strengthening health systems and improving the quality of care to reduce both mortality and some morbidity
 - Reducing hemorrhage, which can lead to death, is related with anemia and other complications
 - Increasing access to skilled birth attendance and EmOC will also reduce fistula
- Maternal morbidity (near misses) can be used to audit care
- Costs of care can inhibit use

Increase access to facility- and community-based maternal health care

- Systematic review of 27 studies of community-based maternal health care interventions (Lassi et al., 2010):

“led to reductions in maternal morbidity... increased referrals to health facility for pregnancy related complications... improved the rates of early breastfeeding...and improved other mother and newborn care related outcomes”



Expand access to reproductive health care, including contraception

- Reducing unintended pregnancies will reduce morbidity (and mortality)
- Doubling current global investments in family planning and pregnancy-related care (from around \$11.8 billion to \$24.6 billion) would:
 - reduce the annual number of unintended pregnancies from 75 million to 22 million
 - Reduce unsafe abortion by almost three-quarters (Guttmacher Institute, 2010)

Address the antecedents to poor maternal health

- These conditions all take a toll on women's physical and mental well-being:
 - Poor nutrition
 - Insufficient sanitation
 - Lack of schooling
 - Lack of agency in families and societies
 - as well as exposure to gender-based violence
 - Gender norms that expect women to be stoic and to suffer in silence and not reveal events at birth



Expand the Continuum of Care

- Continuum of care approach has gained currency
- Its focus on women in the post-partum period is not sufficiently long to cover longer-term or chronic morbidity
- Does not address intergenerational issues

Maternal Health: Focusing on Mortality AND Morbidity



Mortality *and* Morbidity

Thank you

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