The **Burden** of Poor Maternal Health

**Staggering numbers**

- 210 million pregnancies
- 140 million births
- 303,000 maternal deaths
- 27 million morbidity episodes from five key obstetric causes

The **Burden** of Poor Maternal Health

- Progress has been made in reducing maternal deaths
- Between 1990 & 2015, maternal mortality decreased by 44 percent: from 385 per 100,000 live births to 216 per 100,000

The **Burden** of Poor Maternal Health

**Diversity**

![Graph showing the percentage of maternal deaths due to Haemorrhage and Indirect causes in different regions (S Asia, Latin Amer, Sub Sah Africa, High income) for 1990 and 2013.](image)

- **Haemorrhage**:
  - S Asia: 23% (1990), 19% (2013)
  - Latin Amer: 18% (1990), 15% (2013)
  - Sub Sah Africa: 15% (1990), 13% (2013)
  - High income: 10% (1990), 9% (2013)

- **Indirect**:
  - S Asia: 12% (1990), 10% (2013)
  - Latin Amer: 8% (1990), 7% (2013)
  - Sub Sah Africa: 6% (1990), 5% (2013)
  - High income: 4% (1990), 3% (2013)

In 1990, the pooled maternal mortality ratio for 10 countries with highest levels were 100 times greater than for the 10 with the lowest.

By 2013, the gap had doubled to 200 times greater.
Coverage of services

- Three-quarters of women globally now deliver with a skilled birth attendant
- This dramatic increase occurred mostly via facility deliveries

Facility deliveries by country (1990-2014)

Conceptualizing pathways to care

The scale, scope, coverage & capability of childbirth care. Lancet 2016
How do women get to childbirth care?


The scale, scope, coverage & capability of childbirth care. Lancet 2016
Who does deliveries? And where?

Nigeria

- Home alone
- Home non-SBA
- Home SBA
- Facility alone/non-SBA
- Lower nurse/midwife
- Lower doctor
- Hospital nurse/midwife
- Hospital doctor

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Percentage of deliveries

The scale, scope, coverage & capability of childbirth care. Lancet 2016
Where do deliveries take place?
What are facilities capable of?

% of facility births in facilities in **Kenya** that can provide:

- **Infrastructure**
  - Yes
  - Partial
  - No/poor

- **Routine care**
  - Yes
  - Partial
  - No/poor

- **BEmOC**
  - Yes
  - Partial
  - No/poor

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The scale, scope, coverage & capability of childbirth care. Lancet 2016
Summary I

Burden of poor maternal health (Graham et al)
-> Progress but... diverse maternal health needs will require diverse maternal services

Landscape of maternal healthcare services in low- and middle income settings (Campbell et al)
-> We need to ensure skilled providers for routine and emergency childbirth care, along with timely access to such care

**Too little, too late**
- Lack of evidence-based guidelines
- Women delivering alone

**Too much, too soon**
- Routine inductions/augmentations
- Routine PP antibiotics
- Unnecessary CS

**Appropriate, Timely, Evidence-Based, Respectful Care**
HICs: Key Findings

• Not enough facilities offer women-centered care
• Most countries lack surveillance systems for maternal deaths or identifying causes death.
• Protocols, drills, and simulations for team training are being used to address preventable mortality, such as hemorrhage
• HICs experience variations in practice that are not evidence-based nor attributable to size of facility
• Malpractice liability might pose a barrier to optimal maternity care in North America, especially USA,
  – reduces number of obstetricians willing to pay
  – contributes fear-based over interventionism
Evidence for change: MIC/HIC

- **Type of care provider**
  - *Integrated* midwifery-led care reduces interventions with no adverse effects

- **Remuneration**
  - Fee for service may increase financial incentives.
  - Eliminating payment for early elective induction of labour shows some success in decreasing rates

- **US: fear of litigation**
  - States with high malpractice insurance premiums had higher CS rates
  - No-fault systems (state-supported provision for infants with serious neurological birth injuries) to mitigate costs

Evidence-based Respectful Care: Lack of Equity for all Women

- Adolescents & unmarried women
- Immigrants
- Refugees & internally displaced women
- Indigenous women & ethnic or religious minorities
- Living in poverty
- Living in informal urban settlements
- Living in fragile states
- Affected by humanitarian crises

53 million women no childbirth care
The **Current State** of Maternal Health

Progress, but....

- Vulnerable groups are left behind
  - 53 million women no care

- Variable quality of care between and within countries
  - Too much, too soon
  - To little, too late

- Challenge: Implement evidence-based, respectful care for **all** women
The Future of Maternal Health

Maternal health in the next 15 years will depend on social, political, environmental & demographic changes

- Shocks from outside the maternal health field will influence maternal survival: governance, economic growth, urbanization & health crises

- Health system innovations can be leveraged to improve maternal health: universal health coverage, behavioral economics & mHealth
External shock: change in governance

Millennium Development Goals
1990-2015

http://www.un.org/millennium/declaration/ares552e.htm
https://sustainabledevelopment.un.org/
Innovation: universal health coverage

“Means to ensure that people obtain essential health services without experiencing financial hardship”

WHO definition

- Evidence suggests UHC:
  - Increases service use
  - Provides financial protection
  - Improves health outcomes

- Expands access to care for chronic and acute illness

Call to action: 5 key priorities to achieve SDG target (Global MMR <70 per 100,000)

1. Prioritise good quality maternal health services that respond to local needs and meet emerging challenges

2. Promote equity through universal coverage of quality maternal health services

3. Increase resilience and strength of health systems

4. Guarantee sustainable financing for maternal & perinatal health

5. Improve the availability and use of local evidence to inform quality improvement
Priority 1: Quality maternity care for every woman, everywhere

Sepsis & other maternal infections
- Tetanus toxoid; clean delivery; antibiotics; WASH

Other maternal disorders
- Caesarean-section; other emergency obstetric care

Obstructed labour
- Caesarean-section

Hypertensive disorders
- Early identification & timely delivery; magnesium sulphate; calcium; aspirin; anti-hypertensive; caesarean-section

Complications of unsafe abortion
- Family planning; safe abortion services; post abortion care

Haemorrhage
- Uterotonics; blood transfusion; balloon tamponade; surgery; NASG

Indirect causes
- Iron folate supplements; malaria intermittent treatment; insecticide-treated nets; anti-retrovirals

Priority 2: Address inequity

Series highlights growing divergence in equitable use of services and in MMR

Call to action focuses specifically on inequities in access to good quality care:

- Sociocultural factors, such as gender inequality
- Location, because of remoteness or conflict
- Financial constraints
Priority 3: Strengthen health systems

Countries with largest numbers of births have some of lowest densities of midwives & obstetricians (<2 per1000 pregnancies) -- Democratic Republic of the Congo, Tanzania, Kenya, Ethiopia

We need more maternal and newborn health workers, more capable facilities
Priority 4: Sustainable financing

- Capture **expanded domestic fiscal space** for maternal health
- Deploy coordinated and **targeted donor assistance** for vulnerable populations
- Effectively employ **strategic purchasing and performance based incentives**
  - identify models of care & interventions to invest in
  - determine how to purchase; for whom (subsidies)
  - select health-care providers to purchase services from—ideally those who can provide highest quality of care most efficiently

## Priority 5: Better evidence

### Evidence → Action → Accountability

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<tr>
<th>Metrics research priorities</th>
<th>Implementation research priorities</th>
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<tr>
<td>• Standardize definitions &amp; methods for causes of death</td>
<td>Invest in national capacity for locally driven research on:</td>
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<tr>
<td>• Improve Civil Registration Vital Statistics for births, stillbirths &amp; deaths</td>
<td>• Health systems</td>
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<td>• Epidemiology</td>
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<td>• Policy &amp; practice</td>
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Key messages: indicators and measurement

Future measurement ...

“The current indicator of skilled birth attendant coverage is a unidimensional and limited metric with which to characterise complex services; a more diverse range of indicators is needed to capture the nature and content of care being provided; these data are readily available” Campbell et al.
In conclusion...

This series...suggests two fundamental issues:

- ensure the **quality** of maternal health care for all women
- guarantee access to care for those left behind or those most vulnerable

*Countries, and the global community, must take action to reach every woman, every newborn, everywhere with good quality health care*