

Maternal Mortality in South Asia: Epidemiology

Report from the OXFAM India South Asia Consultation

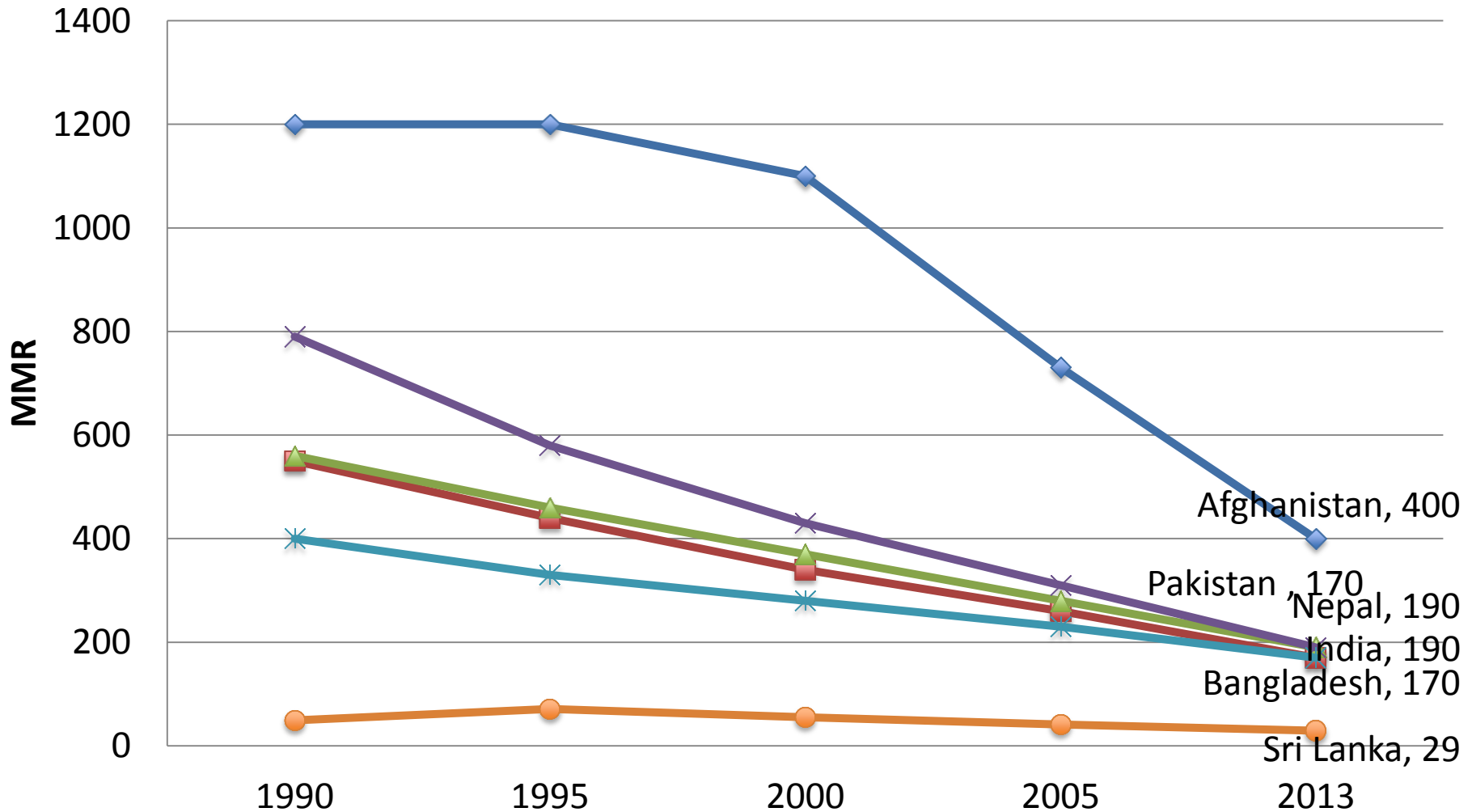
March 31, 2015

Linda Bartlett MD, MHSc.

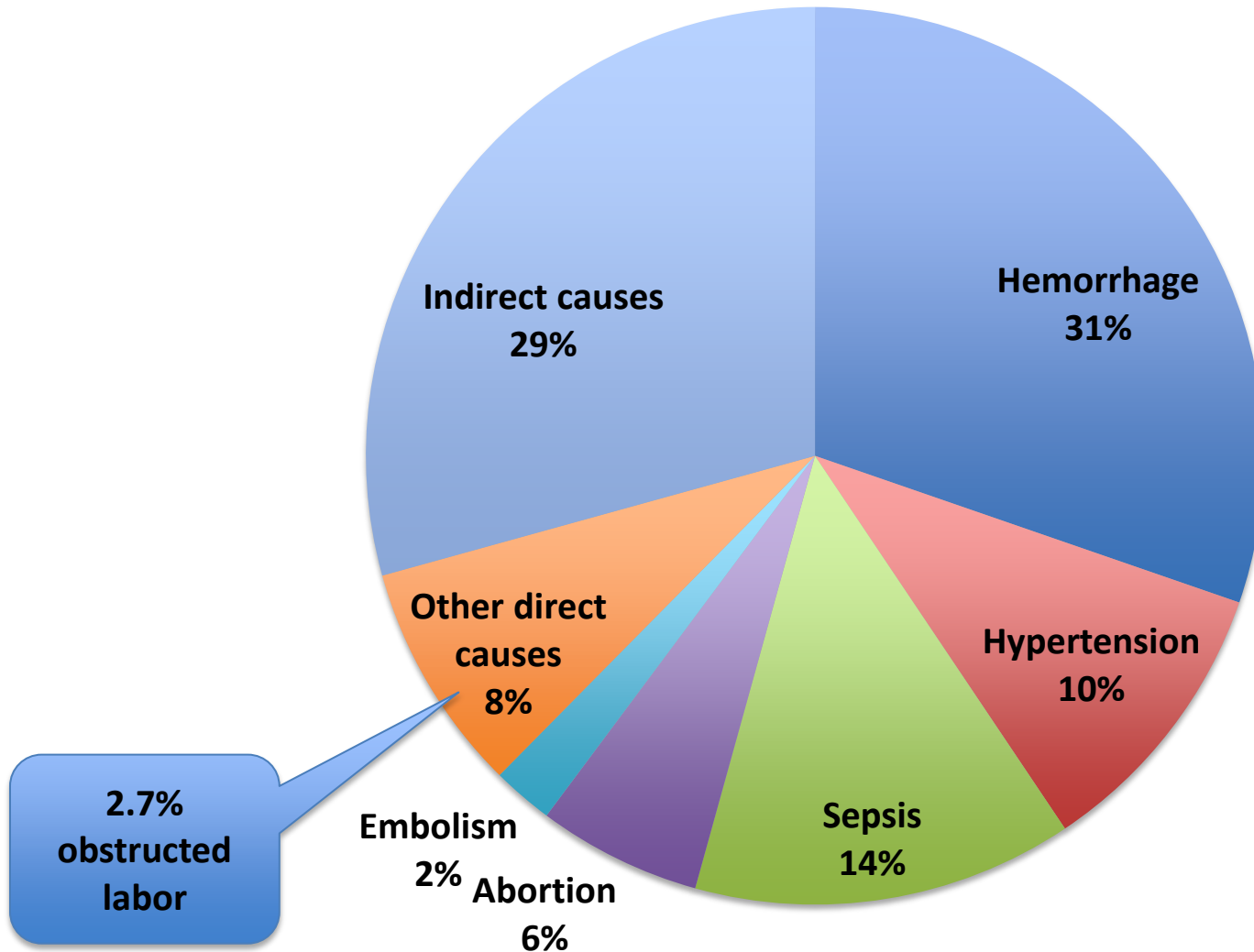


Trends in MMR, South Asia, 1990-2013

Source: WHO, published 2014.



Maternal cause of death distribution, UN, published 2014



COUNTRIES WITH VERY LARGE POPULATIONS, VERY HIGH LEVEL OF DISPARITIES majority rural, with home births and unmet need for family planning

Example - Pakistan:

- Population 180 million (2009)
- 65% of population is Rural
- 4-5 million births/yr
- Nearly 60% of births are home deliveries
- 37% 4+ANC
- 60% PNC
- 55% of married women need family planning
 - 20% these 55% have an **unmet need**

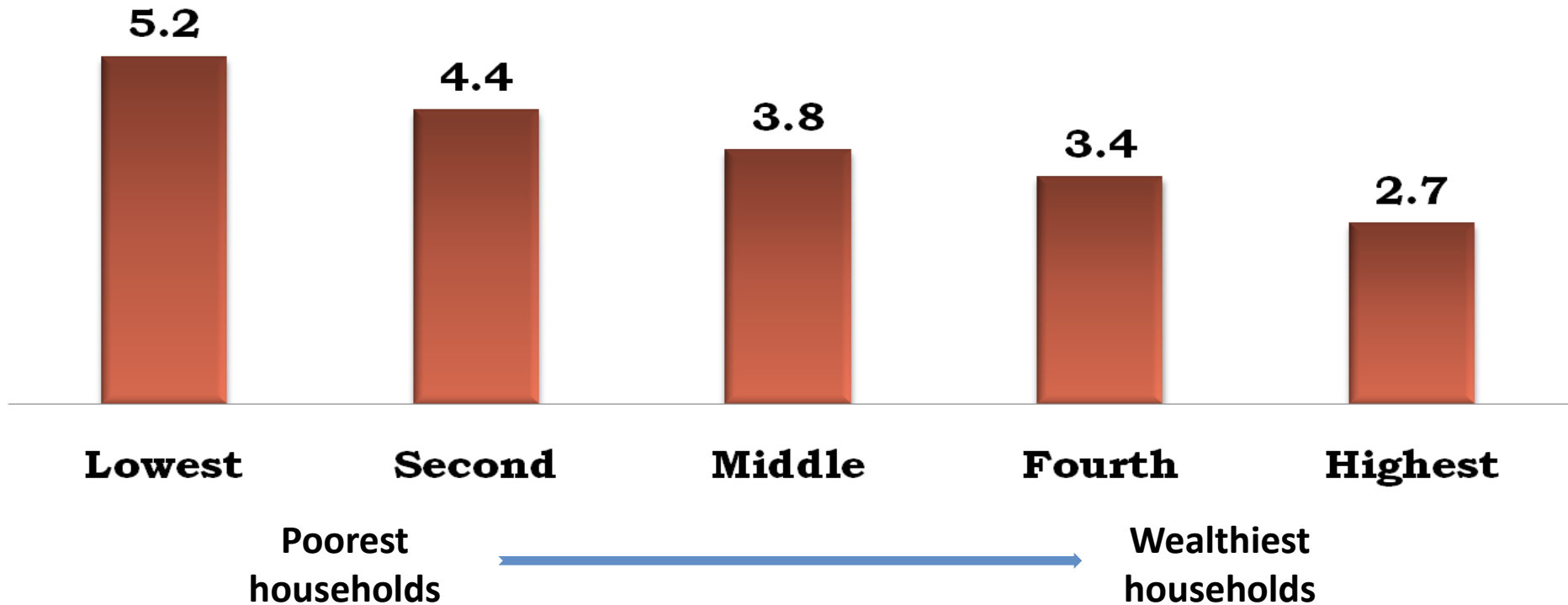
Cause of Death in Adult women

- **Pregnancy related 20.3%**
- Infectious diseases 20.3%
 - TB 10.1%
 - Other infections 10.2%
- Cancer 11.3%

Fertility by Wealth

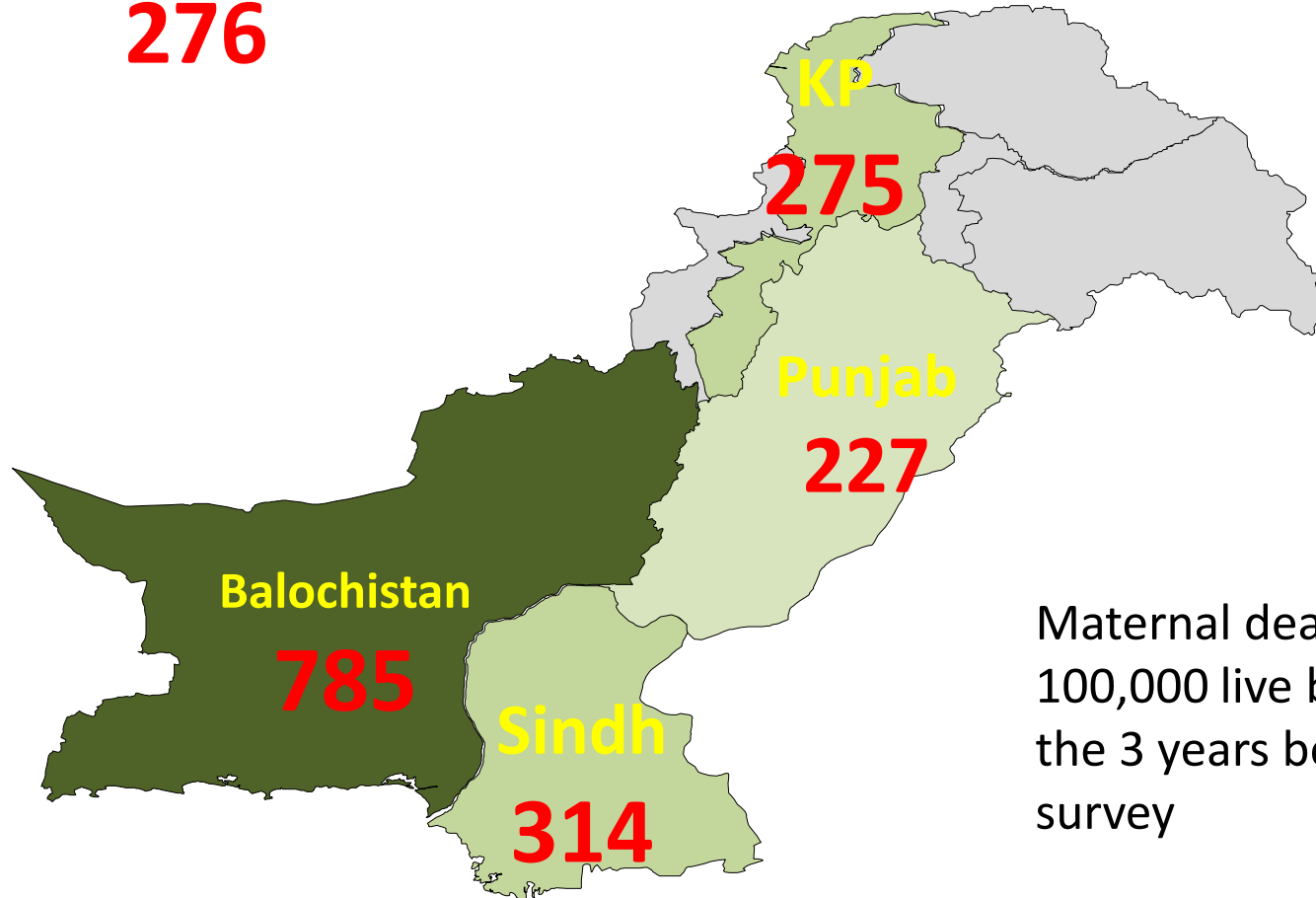
TFR for women age 15-49 for the 3-year period preceding the survey

Overall Fertility = 3.8



Maternal Mortality Ratio

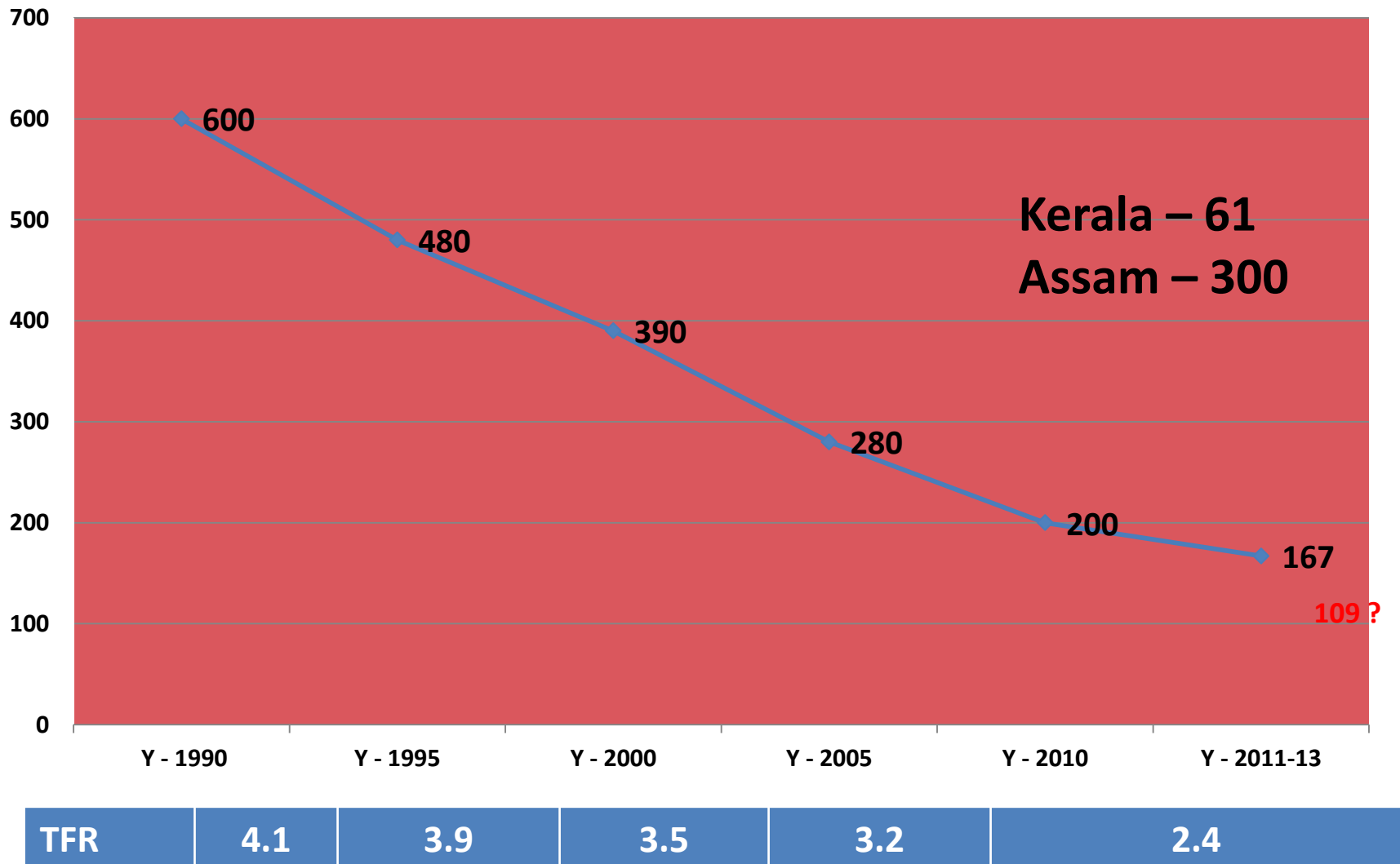
276



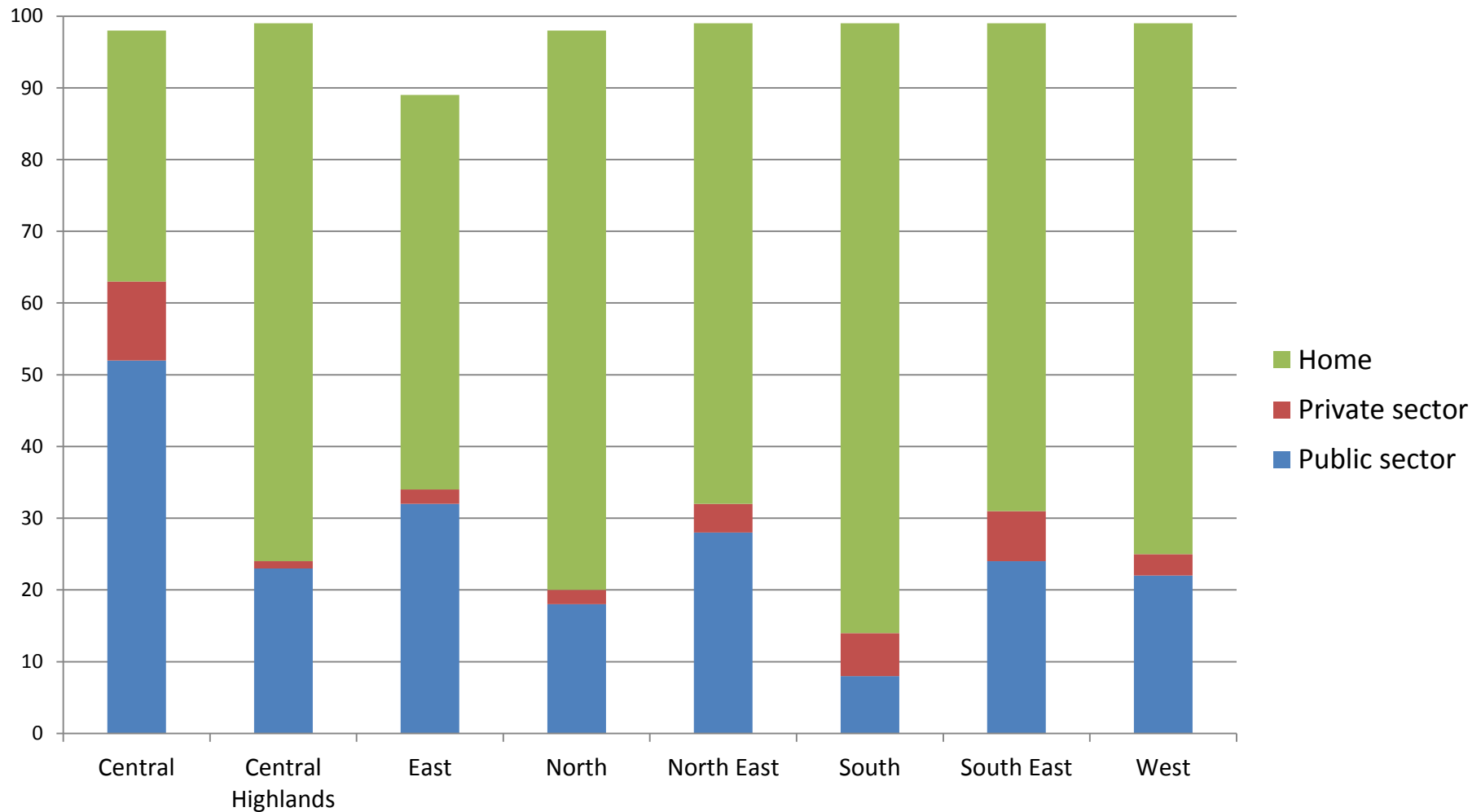
Maternal deaths per 100,000 live births, for the 3 years before the survey

MMR is significantly **higher** in the **RURAL** areas and in **BALUCHISTAN** province

Trends in Maternal Mortality – India

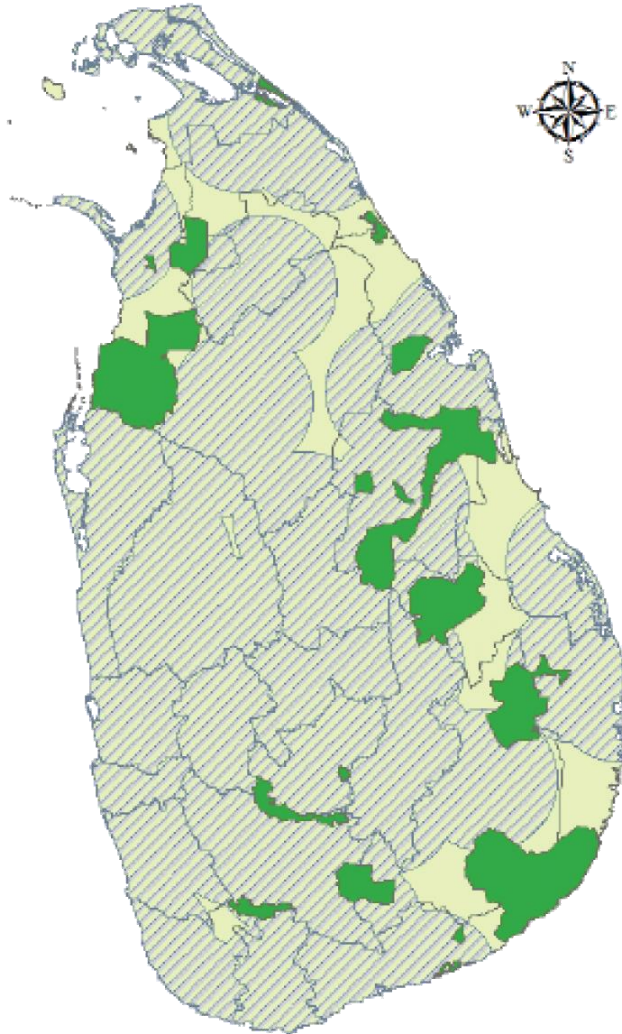


Facility delivery by region, Afghanistan 2010



Source: Afghanistan MICS (AMICS), 2010

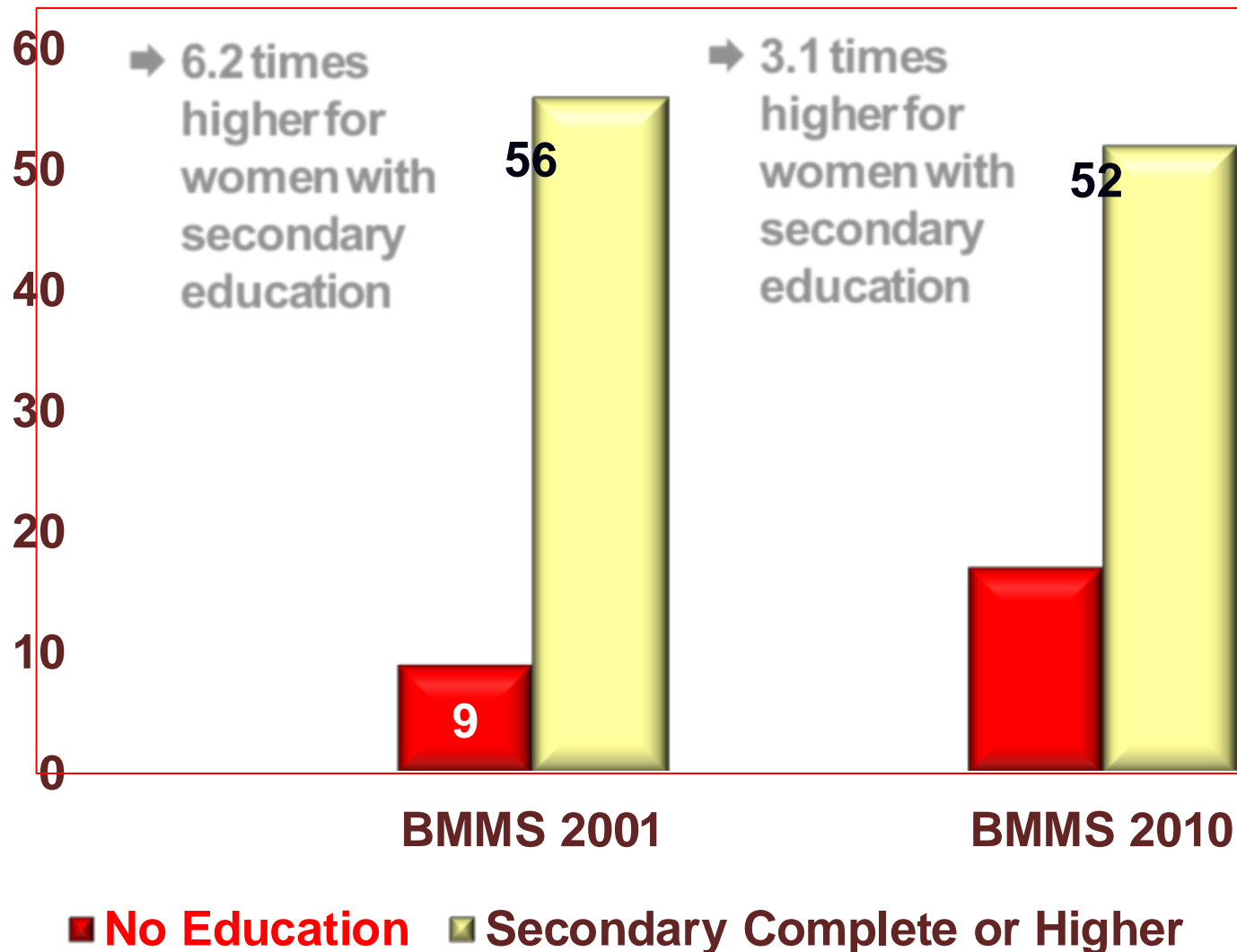
MMR by distance to facility, Sri Lanka



MMR in areas **within** a 30 Km.
from CEmONC facility **35.2** per
100 000 population
(95% CI: 28.8 to 41.5)=

MMR in areas **outside** a 30 Km.
from CEmONC facility = **70.22** per
100 000 population
(95% CI: 43.7 to 104.1)

Education effect on Treatment Seeking for Maternal Complications



Thank you



Small working group discussions

1. Data Needs

**2. Respectful
Maternity Care**



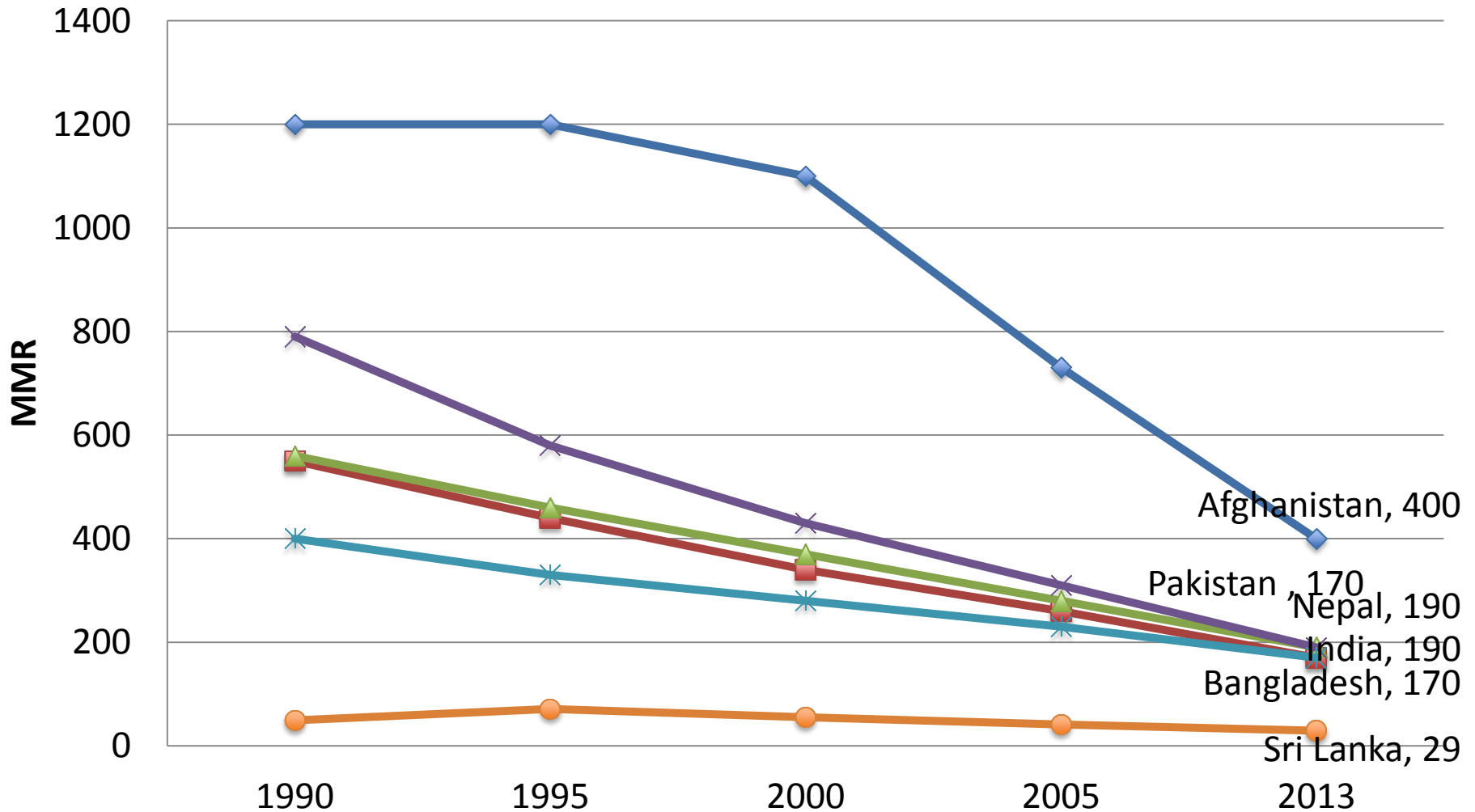
The lack of accurate data is a major obstacle in understanding and improving the maternal health situation in South Asia

“Without data, the ground situation cannot be understood and no real planning can take place”

At national and local levels

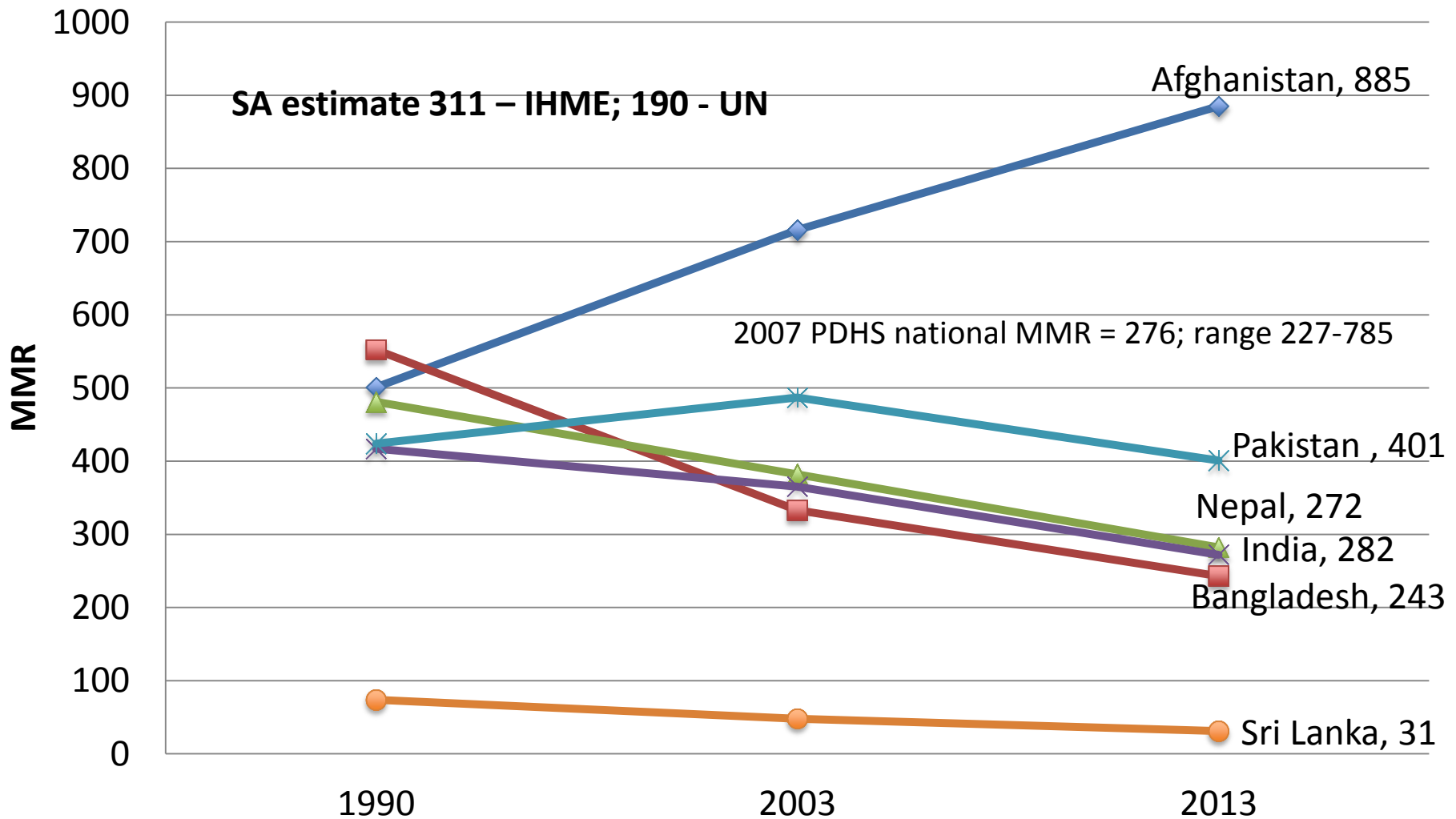
Trends in MMR, South Asia, 1990-2013

Source: WHO, published 2014.



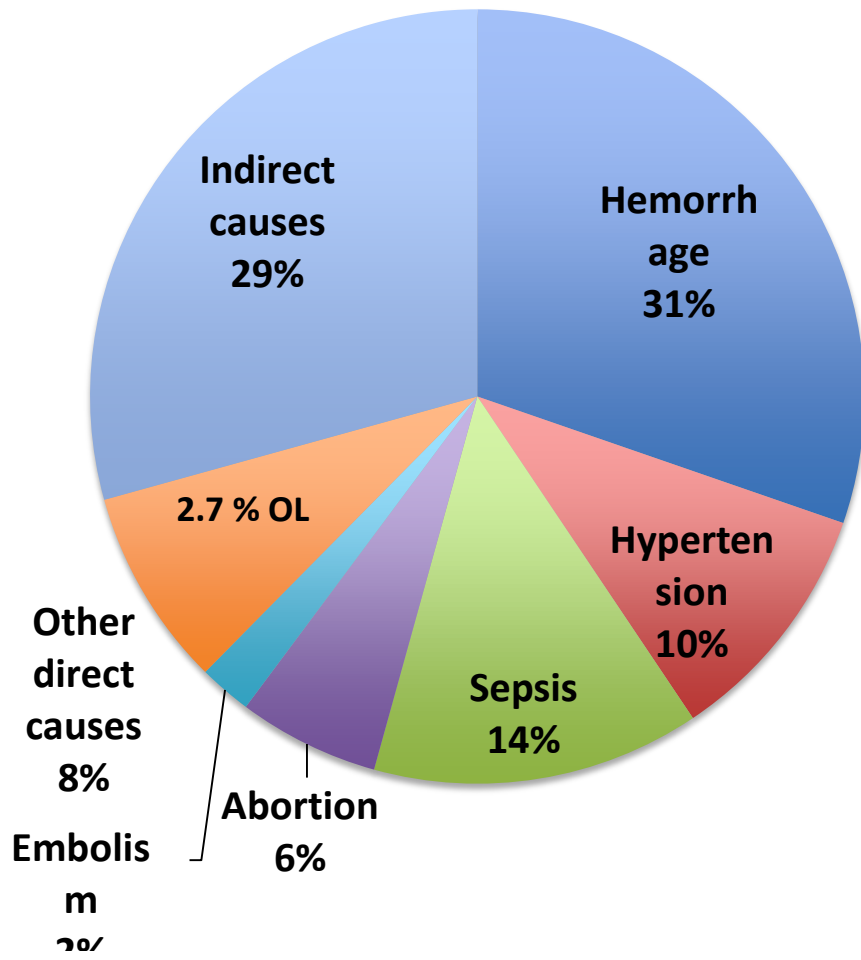
Trends in MMR, South Asia, 1990-2013

Source: IHME, published 2014.

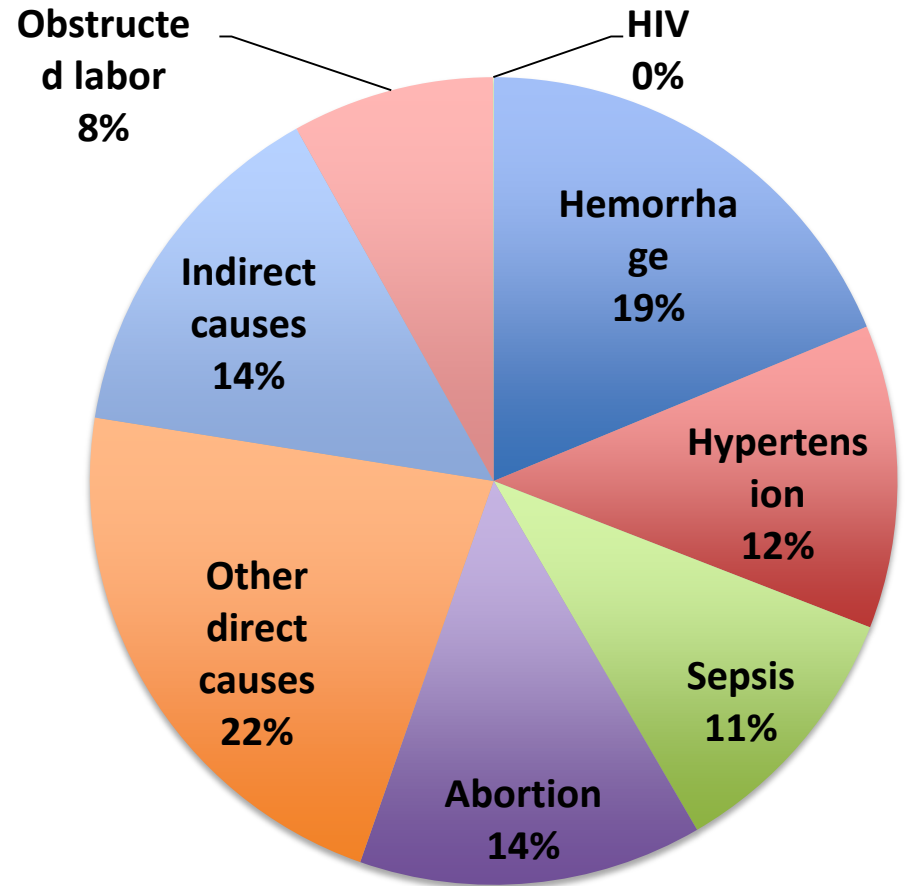


Maternal cause of death distribution, published 2014

UN



IHME



Issues with data availability and quality

Insufficient or no:

- Verification processes at the point of generation
- Access to raw data, only processed data
- Reporting of maternal deaths
- Data on maternal morbidities
- Perceptions of clients (patients) of care received

“There is pressure to deliver and show better results.”

- “In the absence of proper supervision and monitoring, great concern that result-based frameworks have resulted in reporting of 'false' information → 'inaccurate' progress”
- A large amount of data is being collected or generated
- But is almost always quantitative and generated on pre-determined categories
- The user experience left out
- “Data equity” (disaggregated data)

“The purpose of data collection ought to go beyond ‘collection for reporting to higher authorities’.”

- Collected data is rarely analyzed at the level of point of collection – village or district
 - Could help develop understanding and generate action at the local levels.
- Recognition that the information derived from routine HMIS and national statistics is limited
- Little systematic qualitative data to inform user and provider experience
- NGO data of development workers experiences as well as M&E systems and special studies largely unused

Recommendations 1

A more robust data collection process that includes verification for both routine and non-routine (surveys) is needed.

- Example: Frontline health workers who provide data should be trained to look at the perspective of service improvement, not just asked to fill in a data collection sheet.
- Strengthen supportive supervision and monitoring for data collection.
 - Allocate the resources needed.

Recommendations 2

Encourage data usage at all levels. Data should be accessible.

- Ensure rural and vulnerable populations have information collected and available: sub-analyses by gender, ethnicity, caste, etc.

Provide information feedback loop to people.

- Analyzing data at the local levels could generate action at the local levels

Recommendations 3

NGO and funding agencies collaborate to fill gaps with (mostly) existing data

- Examining data generated by NGOs and funders could offer insights into the status of the country.
- E.g.: An annual landscape analyses (shadow report) could be generated by an independent party where data and experiences from a variety of organizations could be collated.

Audit data collection processes and usage: Limit collection to what is needed and being used (purpose oriented data collection)

Recommendations 4

Consider beginning to limit numbers of surveys by external agencies – focus on developing capacity in country

- Develop sample registration systems and strengthen vital registration.
- Develop capacity for qualitative data collection and analyses / implement routinely

Respectful Maternity Care

- WHO definition: providing dignity, true informed consent, open communication, provide all options/choice.



Problem

“Instances of obstetric violence, violation of patients’ rights by physicians and other health personnel, disrespect and abuse in the labour room and corruption are not uncommon in South Asian and other developing countries around the world.”

“Safe motherhood should go beyond mortality and morbidity to include respect for women’s basic human rights which includes dignity, feelings, choices and preferences including companionship during maternity care.”

- Intersection of gender/patriarchy, class, caste, religion and unequal allocation of public resources impact on respectful reproductive health services
- Respect for the women, and accountability, has to be an essential component of any health system.
- Recognize that need to consider constraints that many practitioners work in. E.g. Lack of time, lack of space, lack of access to resources, lack of support, etc. – that need to be addressed.

Recommendations 1

Urgent need to include education on the issue as a component of medical, nursing, midwifery, auxiliary worker education / and employment training

- 2-day workshops in Pakistan by invitation in medical school and midwifery training groups.
- Important that this training doesn't lead practitioners to do something that conflicts with their contexts so much that it might put them at risk. E.g., trying to force husband to accompany wife to L&D. Learn to negotiate, rather than enforce.

Recommendations 2

Make provision of respectful care an important component in accreditation of health centres.

- The idea of promoting ‘mother/woman-friendly’ centres was proposed.
- Partnering with women should be the model-emphasis on women’s choice and control
 - Some one to help guide woman through all of the processes in the hospital at time of birth – midwife, TBA, CHW, daya.

Doctors need to take lead in accountability because they become role models.

- Identify “champions” in medical and paramedical institutions and professional association.
- Start a community of practice on Respectful Maternity Care

Recommendations 3

Bring into advocacy realm

- Bring this issue into broader activist agenda opposing violence against women – media / celebrities
- Involve / activate the community

Accountability

- Exit surveys, or under-cover patients to check on behavior practices of med practitioners.

Consider using model of AIDS activist movement against discrimination of HIV+ patients in medical arena. E.g work of Lawyer's Collective

- Create demands for rights and entitlements among patients.

Priority next steps from both small groups

- Disaggregated data must be collected and available - to understand and document disparities, and plan for interventions
- Promote and support data use for decision-making at the local level
- Raw data easily accessible

- Protocol for conduct of providers with clear guidelines (GL) for actions in case of violations
- Education / guidance should be part of pre-service and in-service education curriculums
- Involve community - Demand for respectful care / communicated to community as well.

Thank you



Photo credit: UNICEF

Obstetric transition

