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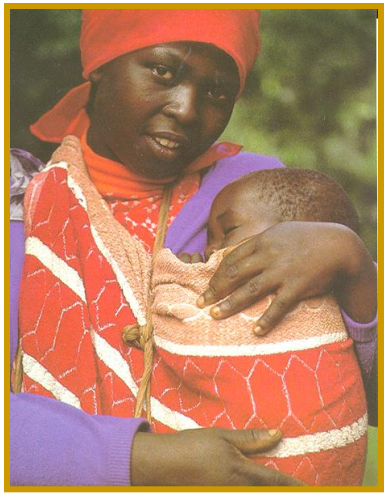
Ending preventable maternal deaths worldwide by 2035: A proposal

April 8, 2013



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Ending Preventable Maternal Mortality requires …

Geographic Focus

- Intensify programs where most maternal deaths occur

High Burden Populations

- Address barriers and scale up access towards equity and respectful maternal and newborn care for those now underserved

High Impact Practices

- Base the maternal health strategy on the local causes of maternal and newborn death
- Strategy should emphasize
    1. Family planning
    2. Quality respectful intrapartum and immediate postnatal care with effective referral
    3. Provide prevention and treatment for obstetric complications and co-morbidities that increase maternal deaths—HIV/AIDS, malaria, tuberculosis, and poor nutrition—during the full spectrum of maternity care.
- Be responsive to emerging health system changes -- financing initiatives, decentralization, privatization, urbanization

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Ending Preventable Maternal Mortality requires …

Supportive Environment

- Educate girls and women—as well as men
- Empower women to demand quality services
- Enact smart policy for inclusive economic growth
- Leverage public, private and professional partnerships

Mutual Accountability

- Promote transparency and shared accountability for financing and results
- Monitor progress against a common set of metrics
- Ensure communications – electronic and mobile technology – and improve documentation/surveillance and mapping to improve the continuum of care and use of knowledge in programming

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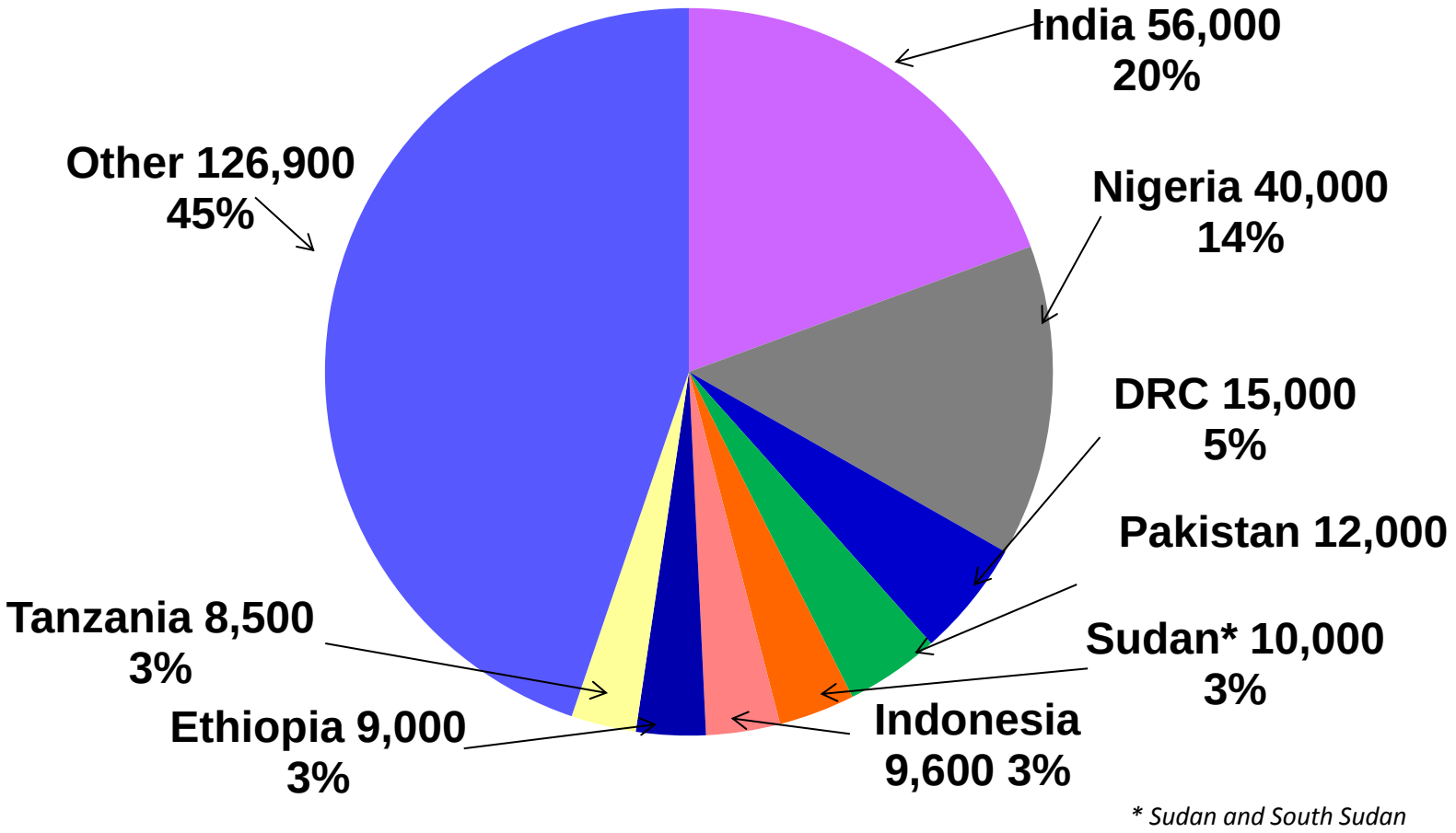
Geographic Focus

Over half of all maternal deaths occur in just eight countries

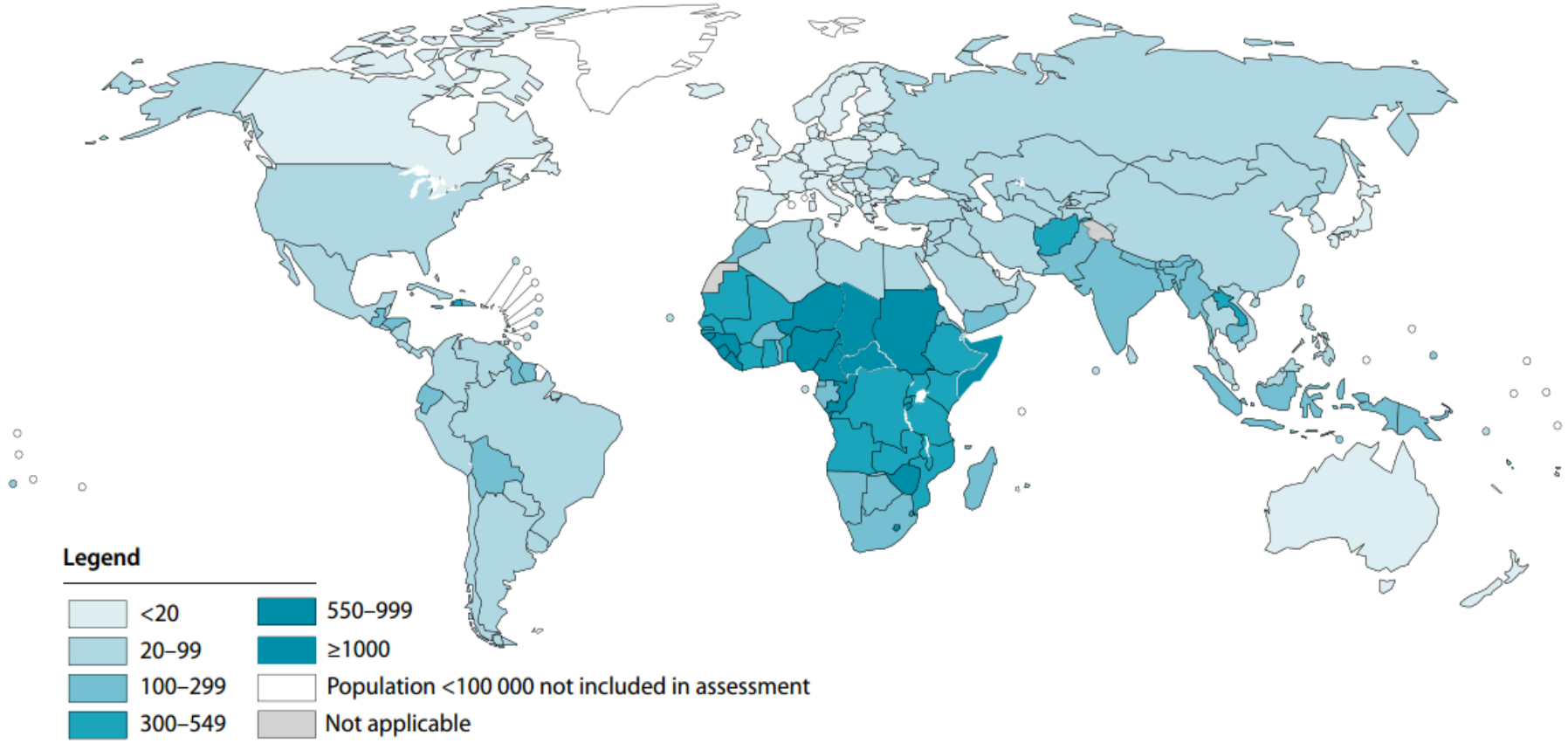


** Sudan and South Sudan*

Source: WHO, UNICEF, UNFPA and the World Bank estimates. *Trends in Maternal Mortality: 1990-2010*

Map with MMR by country, 2010

Figure 1. Map with countries by category according to their maternal mortality ratio (MMR, death per 100 000 live births), 2010



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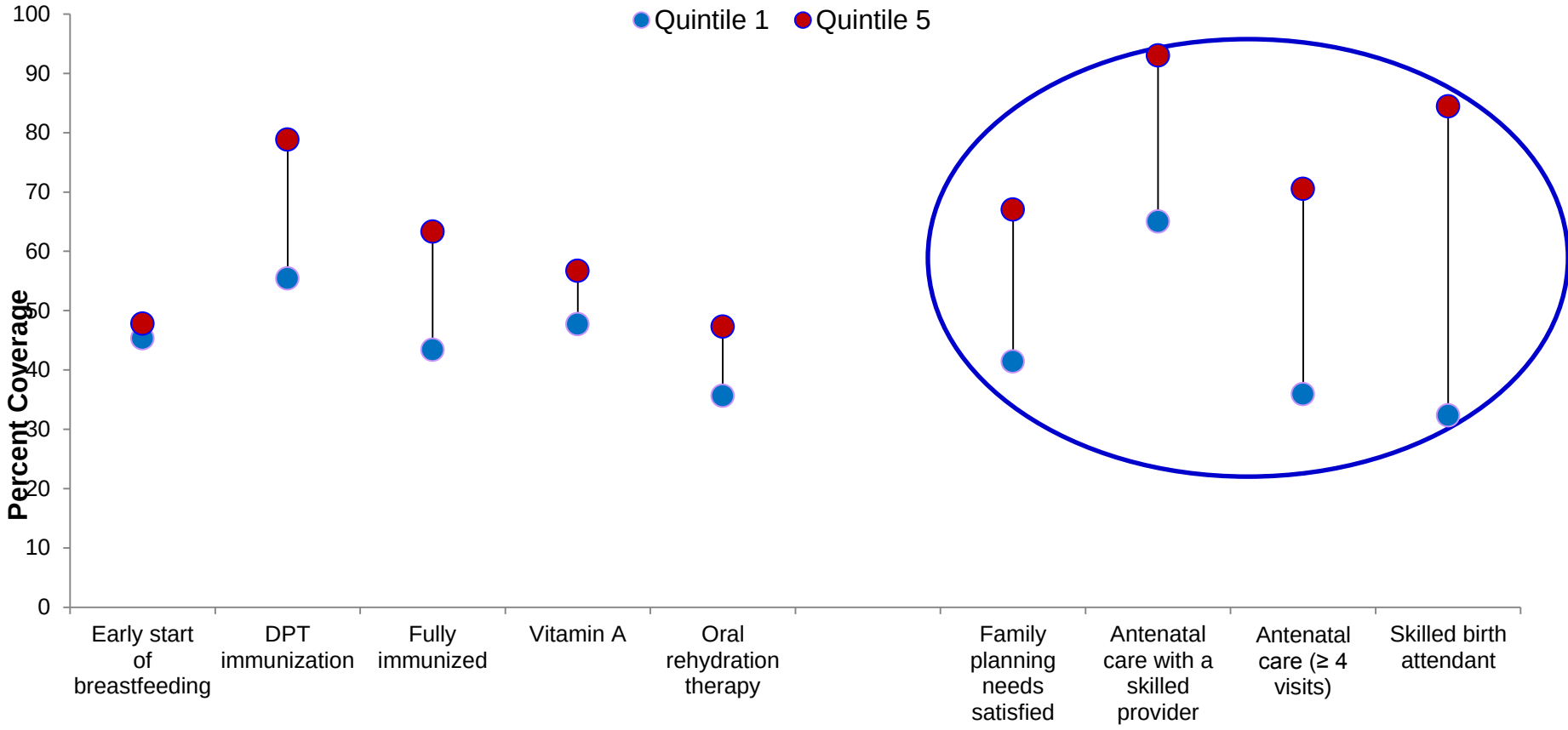
High Burden Population

Maternal coverage indicators show widest gap in equity



Child Health Indicators

Maternal Health Indicators

Barros, Ronsmans, Axelson et al. 2012

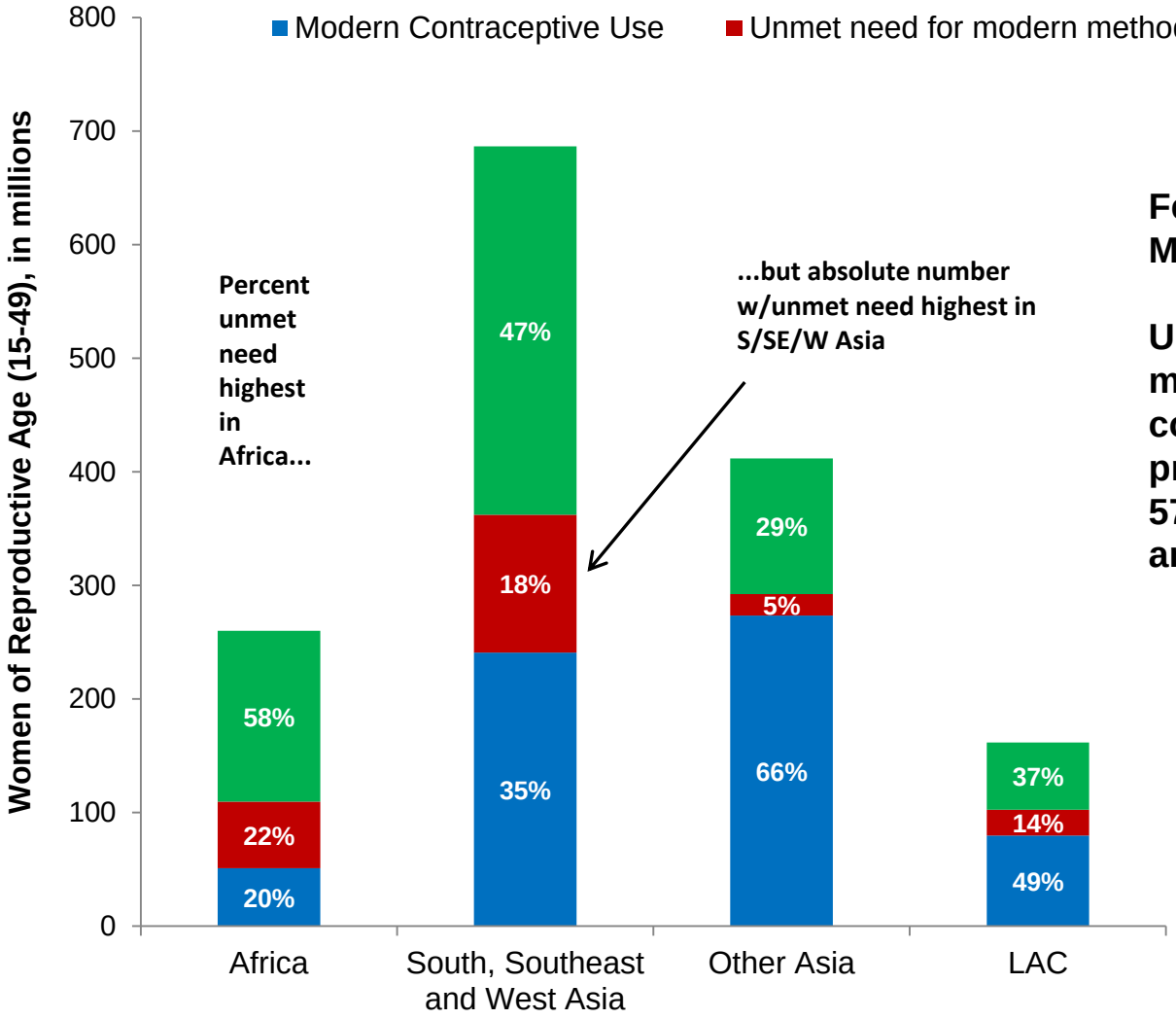
Three ways in which contraceptive use/fertility impact on maternal deaths:

1. Reduces the number of times a woman is exposed to pregnancy (especially an unintended pregnancy) -- In many countries, upwards of 40 percent of pregnancies are unintended (either unwanted or mistimed).

2. Ensures healthy timing -- both younger/older ages and higher parity carry higher risk of maternal mortality.

3. The impact of growing annual number of births on the health system.

Family planning can ensure an intended birth

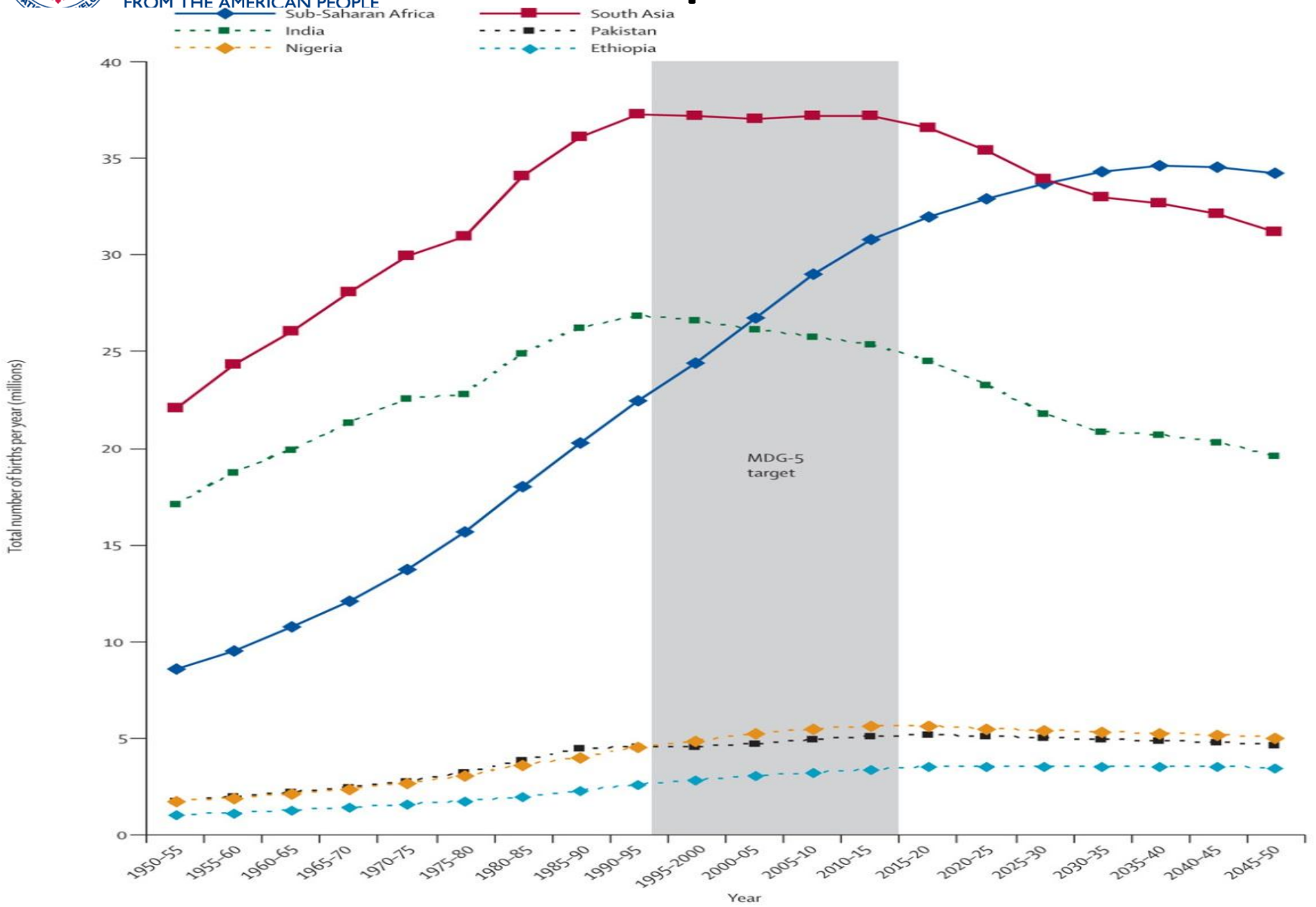


Fertility plays a major role in MMR Reduction:

Unmet need of 222 million women for modern contraception leads to 79,000 pregnancy-related and 572,000 newborn deaths annually

Singh S and Darroch JE, Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.

Causes of maternal death: Population momentum



Source: Ronsmans C et al. 2006. Maternal mortality: who, when, where, and why. Lancet.;368(9542):1189-200.

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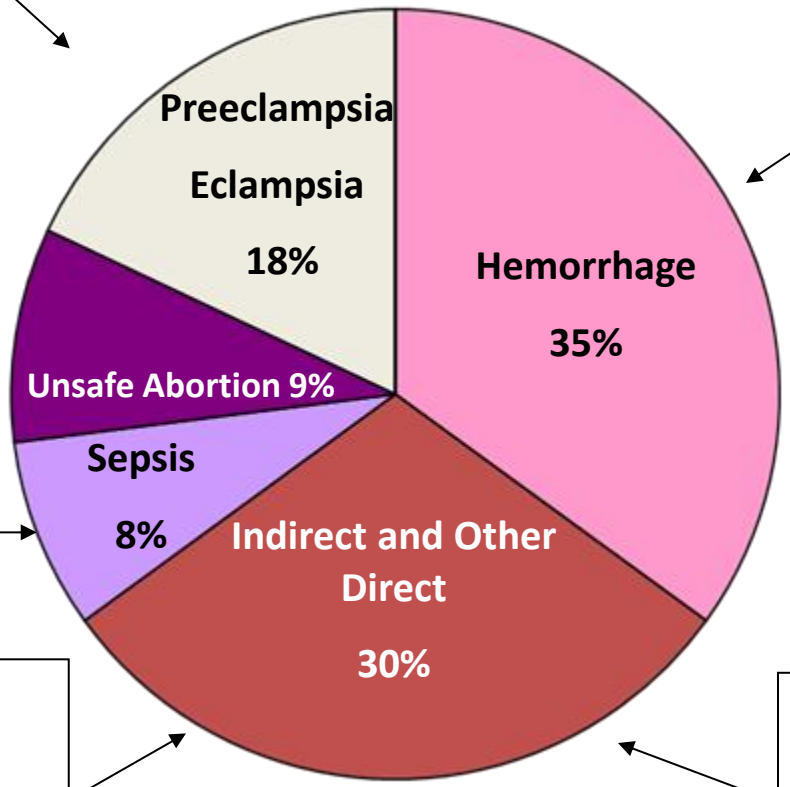
High Impact Practices

Proven interventions can address the leading causes of maternal death, both direct and indirect

- Calcium
- Magnesium Sulfate
- Aspirin
- Anti-hypertensives
- Cesarean section



- Active management of the third stage of labor
- Uterotonics: oxytocin & misoprostol
- Blood transfusion

- Family planning
- Post-abortion care

- Tetanus toxoid
- Clean delivery
- Antibiotics

- Iron folate supplements
- De-worming
- Malaria intermittent treatment
- Anti-retrovirals

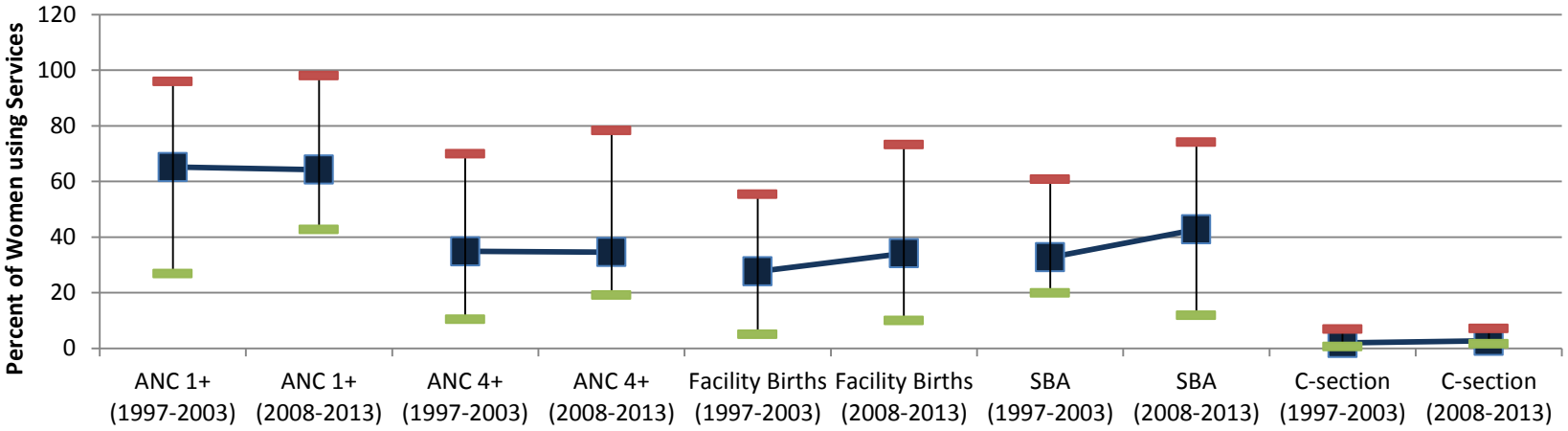
- Family Planning
- Diet, supplementation and fortification

Underlying causes:
- Unintended pregnancy
- Under-nutrition
- Co-infections

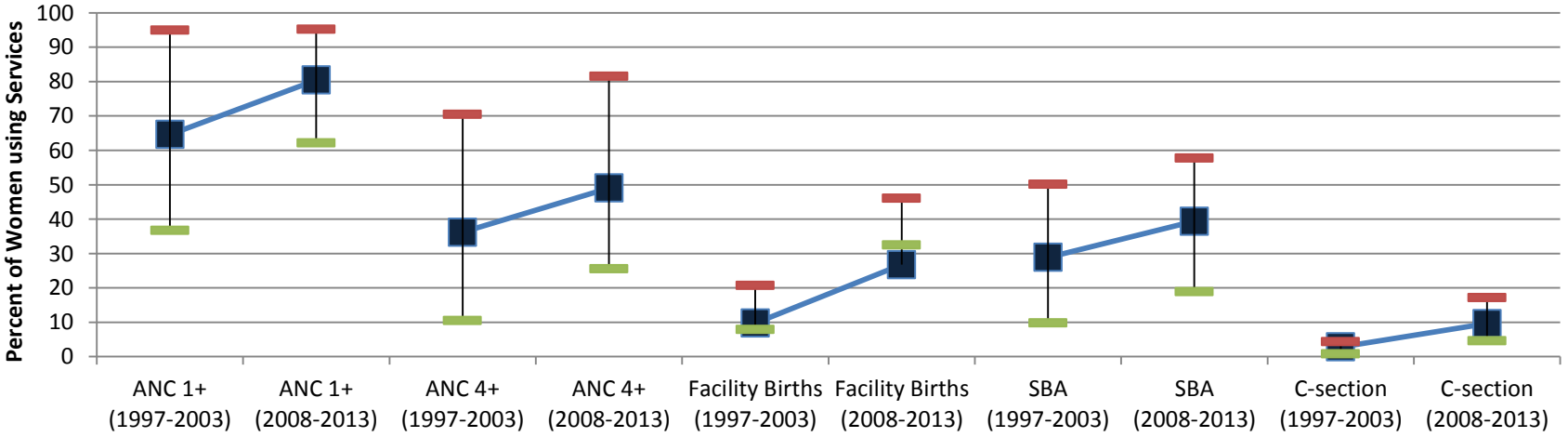
Source for Causes: Countdown to 2015

Increase in MH Services Utilization over Decade

African MCH Priority Countries by DHS Survey Phase



Asian MCH Priority Countries by DHS Survey Phase



Quality of care is critical: an important part is respect

- A **"veil of silence"** has obscured widespread humiliation and abuse of women in facilities during childbirth, a time of intense vulnerability for women.
- In many settings, **disrespect of women in childbirth has been "normalized"** and is sometimes accepted by women themselves.
- Institutional disrespect and abuse of women **can significantly deter women's use of facility skilled care** for normal and emergency birth care.

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Increasing demand for services: Applying the financial "lever

Financing Approaches

- Health Insurance
- Conditional cash transfers
- Vouchers
- Free services
- Pay for performance

Rwanda progress

There is a correlation between increased enrollment in **health insurance** and increased institutional deliveries

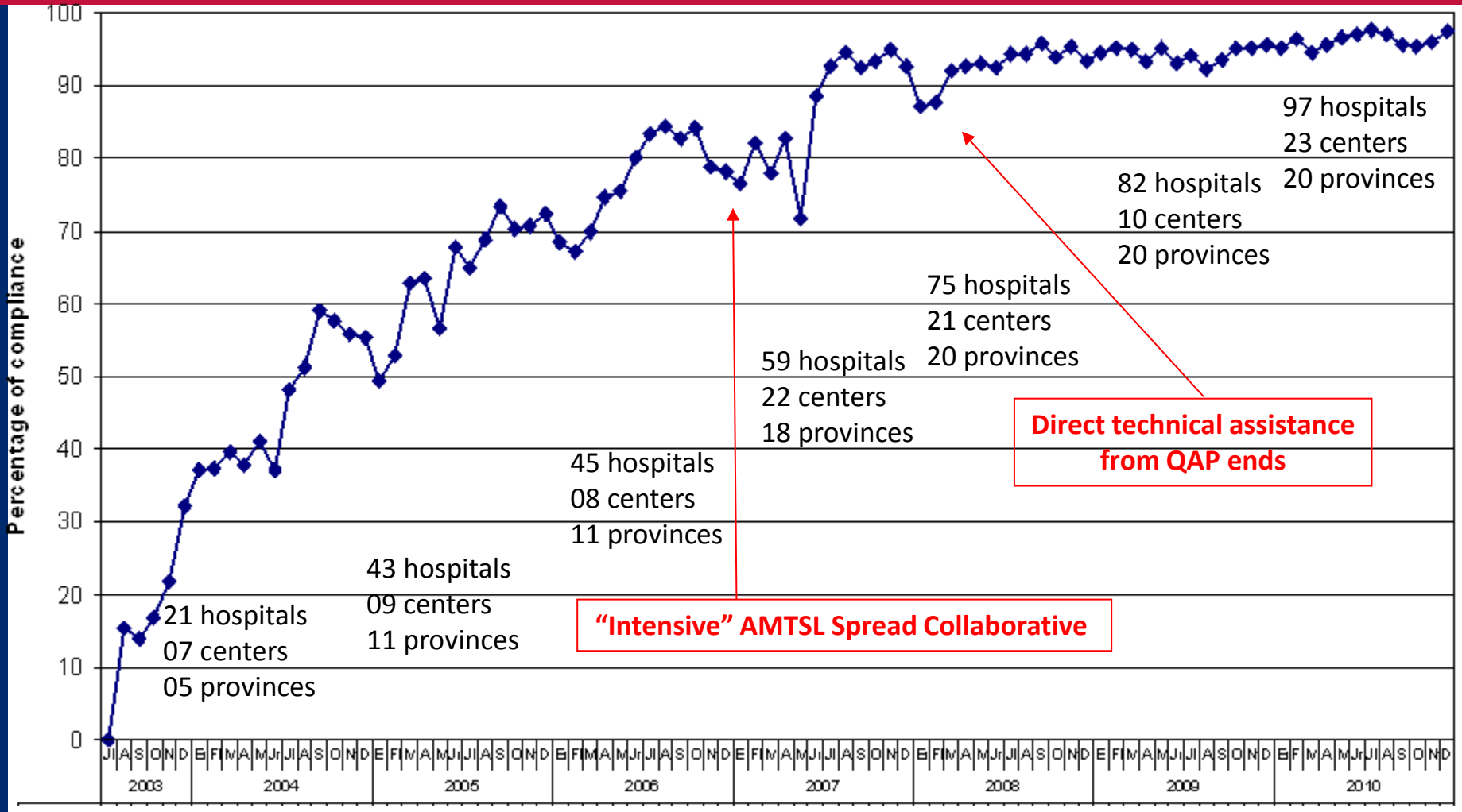
National scale-up efforts have increased coverage from 7% in 2003 to 91% in 2010

Institutional deliveries have increased from 31% in 2000 to 52.10% in 2008

Recent research has shown a correlation between **pay for performance** (P4P) and an increase in institutional deliveries by 21.1%

Sources: Rajkotia and Charles/USAID; Soucat/WB

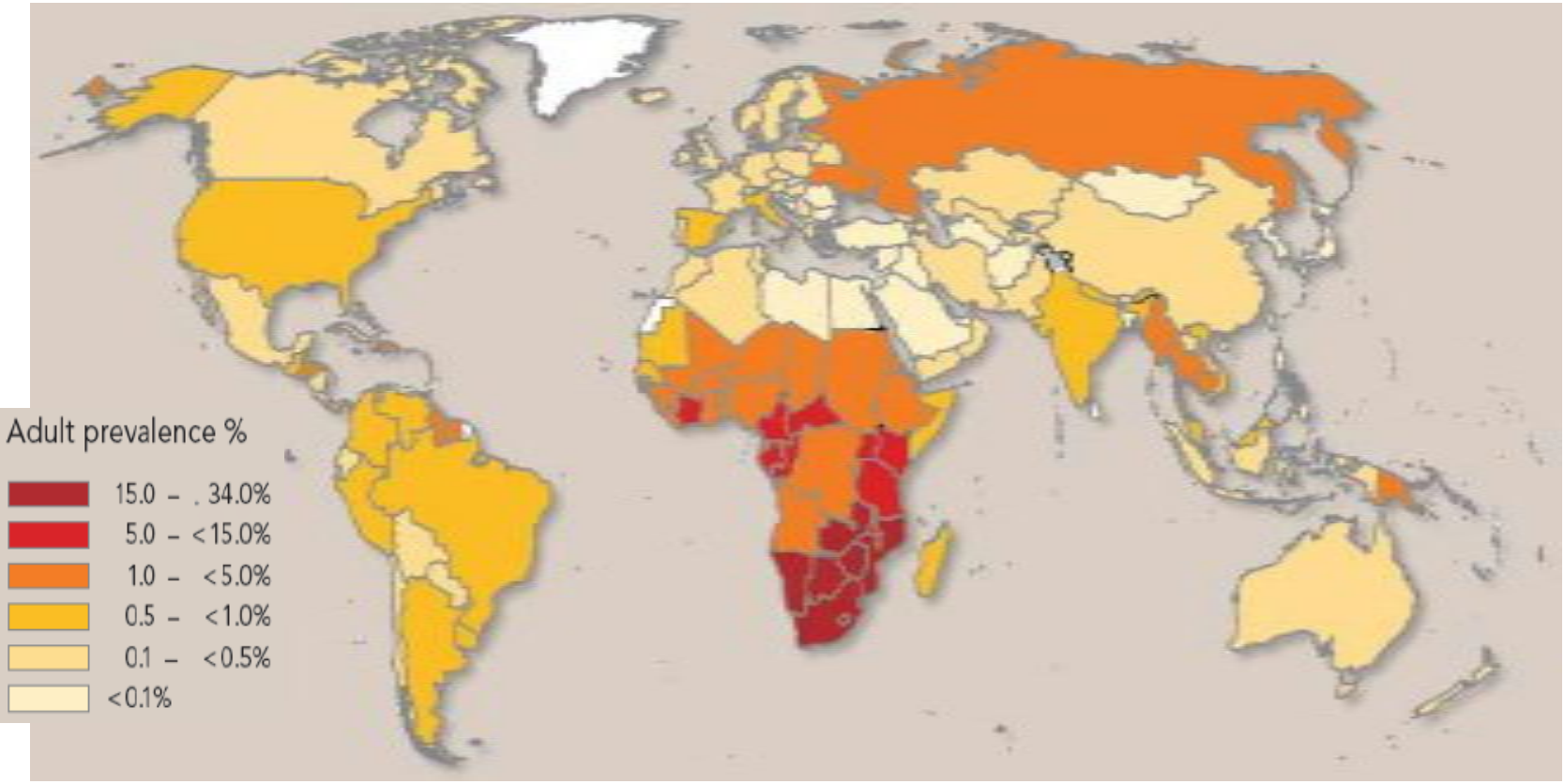
Improving service quality: Quality improvement has resulted in sustained use of AMTSL to prevent postpartum hemorrhage -- Ecuador



Source: University Research Corporation.

Indirect Causes of Maternal Mortality

Heterogeneity of HIV Epidemics Worldwide



Prevention responses need to be tailored to diverse epidemics

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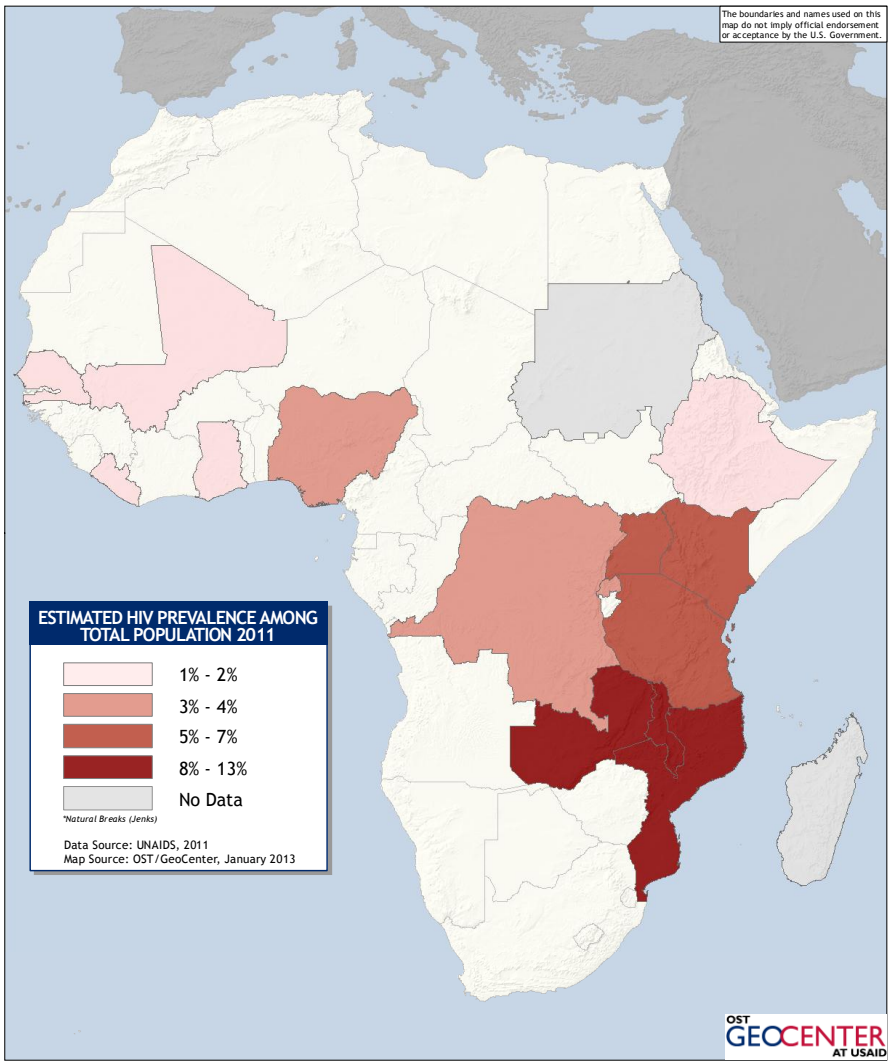
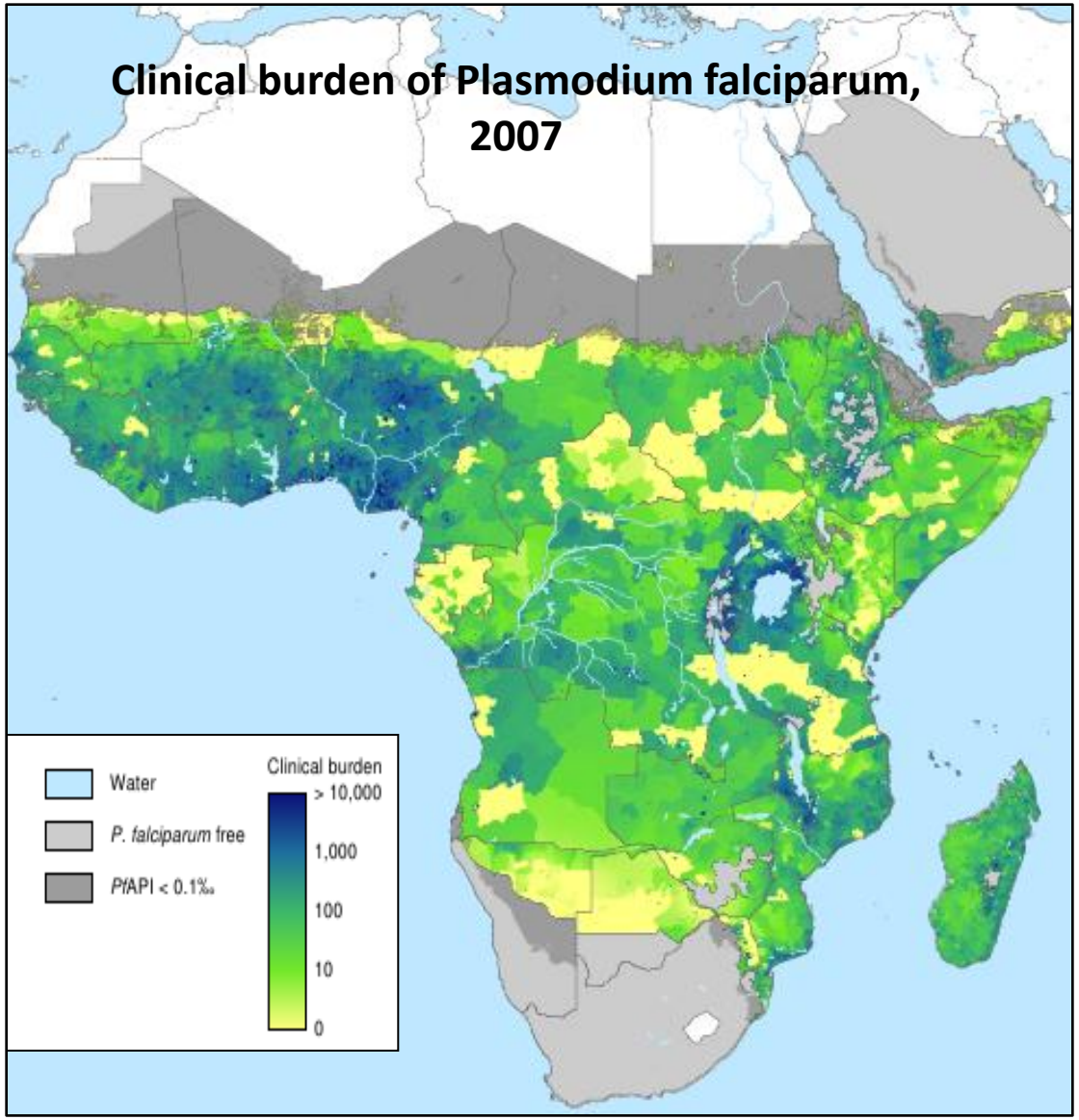
In SSA, the proportion of indirect vs. obstetric causes is greater than in South Asia – reflecting the important contribution of infectious diseases to maternal mortality in Africa



Country	HIV burden	MMR
Mozambique		490
Zambia		440
Malawi		460
Kenya		360
Uganda		310
Tanzania		460
Nigeria		630
DRCongo		540
Rwanda		340
Senegal		370
Ethiopia		350
Rwanda		340
Mali		540
Ghana		350

Source: MMRs: Trends in Maternal Mortality: 1990 to 2010 WHO, UNICEF, UNFPA and The World Bank Estimates, WHO 2012

Maternal mortality is also high in areas of epidemic and endemic malaria



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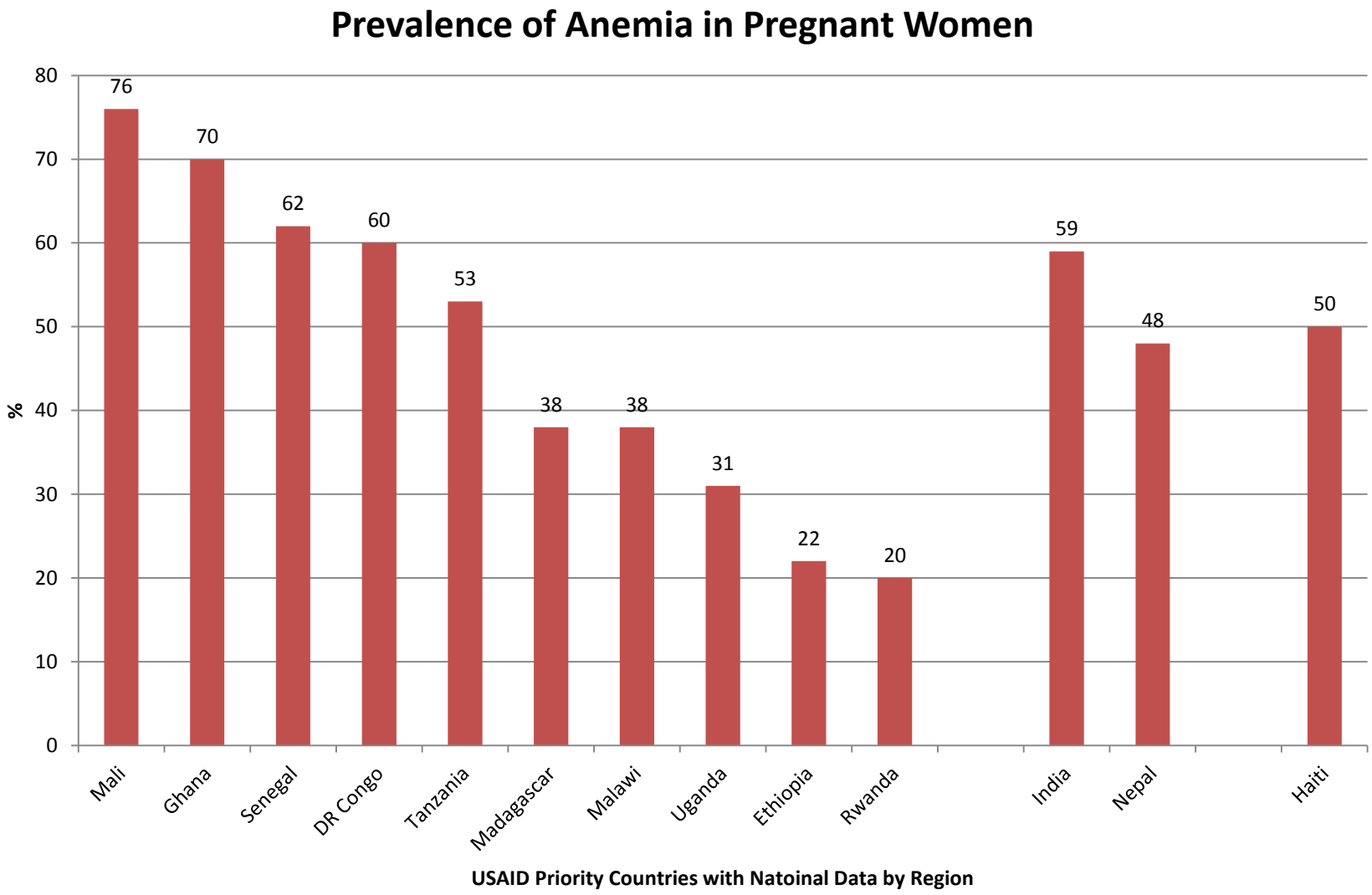
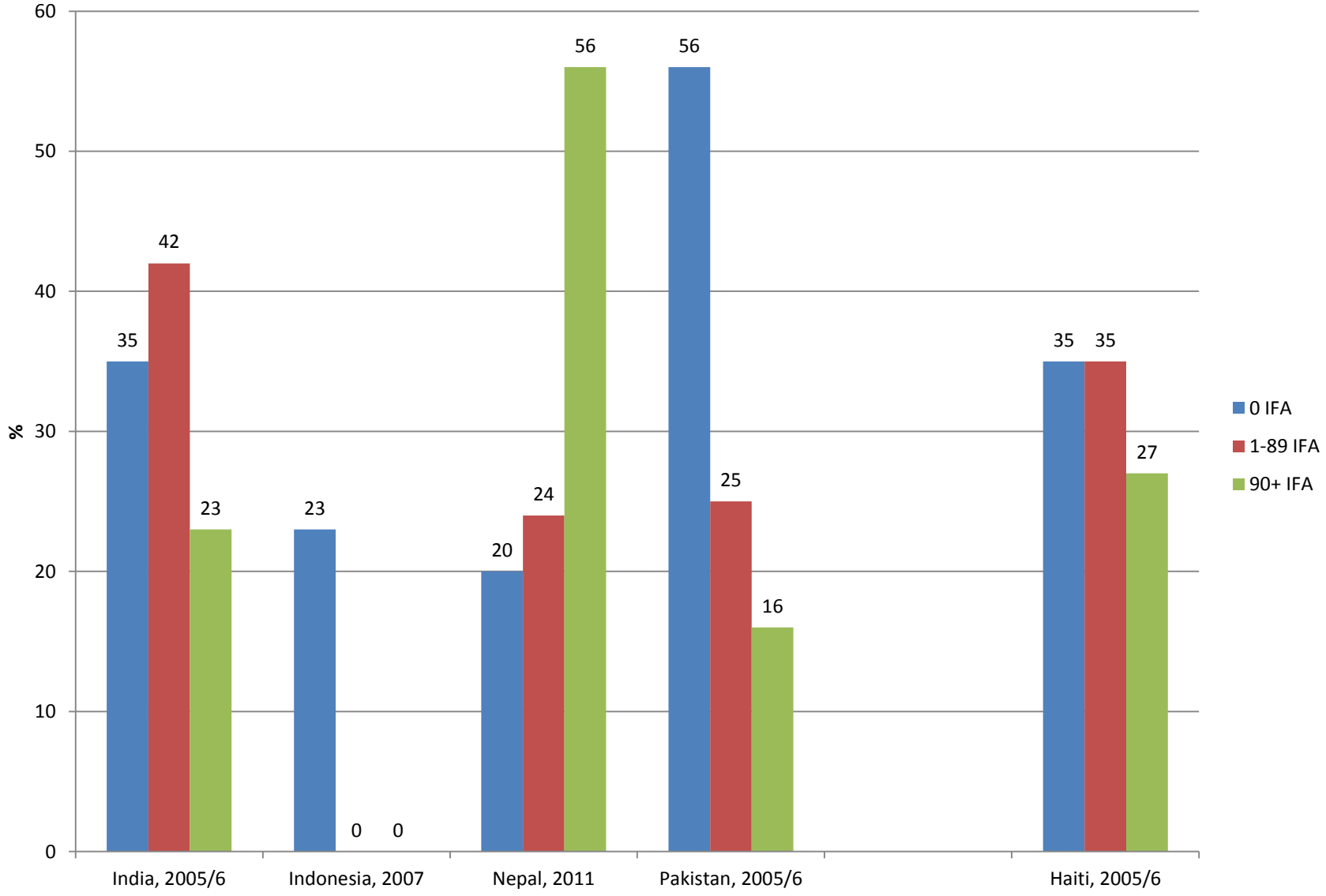
Tanzania	460
Nigeria	630
DRCongo	540
Rwanda	340
Senegal	370
Ethiopia	350
Rwanda	340
Mali	540
Ghana	350
Liberia	770
Senegal	370
Madagascar	240

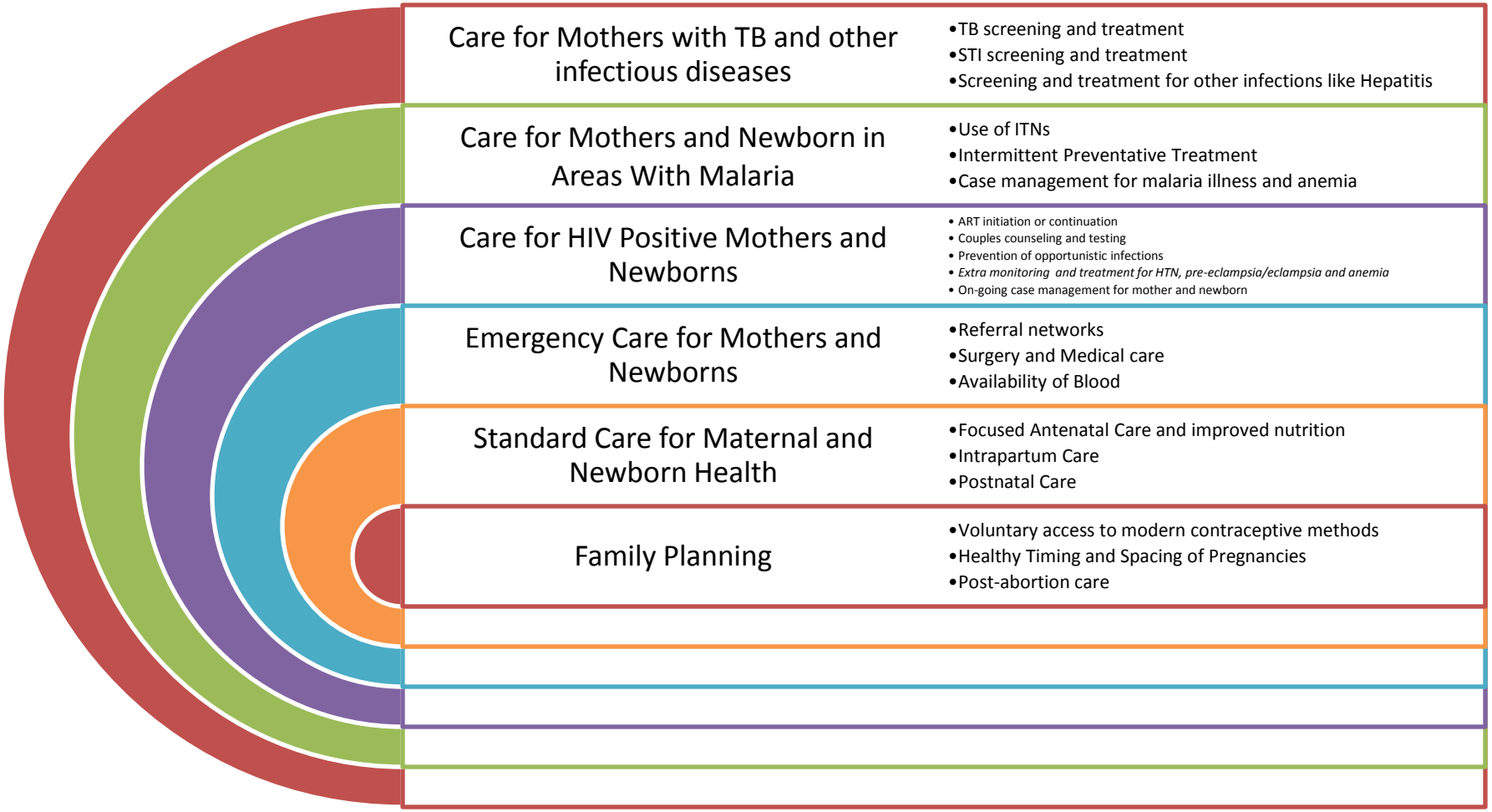
Source: 2010 Malaria Atlas Project, available under the Creative Commons Attribution 3.0 Unported License.


Prevalence of Anemia in Pregnant Women
%
80
70
60
50
40
30
20
10
0
76
70
62
60
53
38
38
31
22
20
59
48
50
Mali
Ghana
Senegal
DR Congo
Tanzania
Madagascar
Malawi
Uganda
Ethiopia
Rwanda
India
Nepal
Haiti
USAID Priority Countries with Natoinal Data by Region

Coverage of IFA in Pregnancy for Selected USAID Priority Countries



Care during pregnancy, childbirth and beyond



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Contextual Challenges

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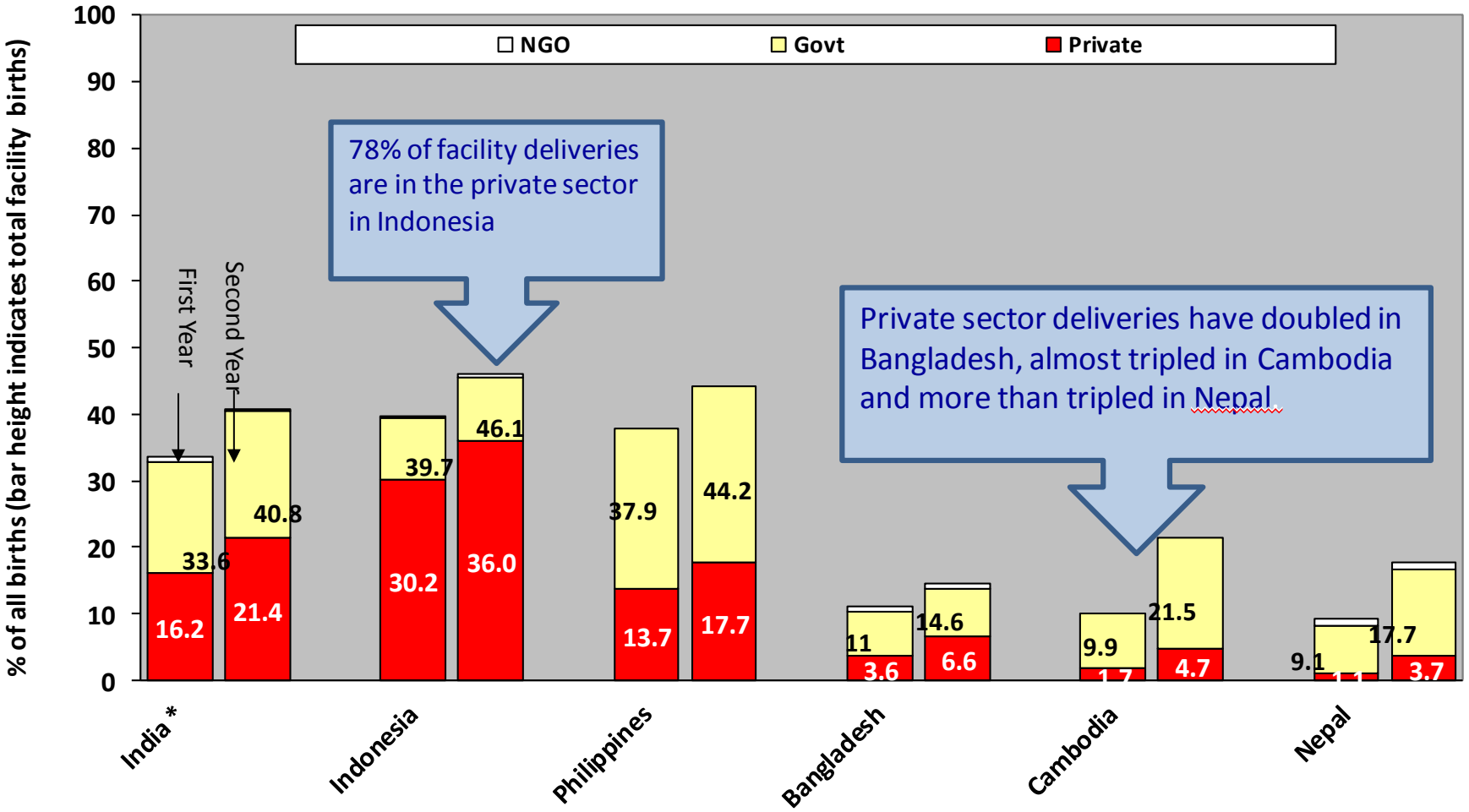
Changing Health System Context

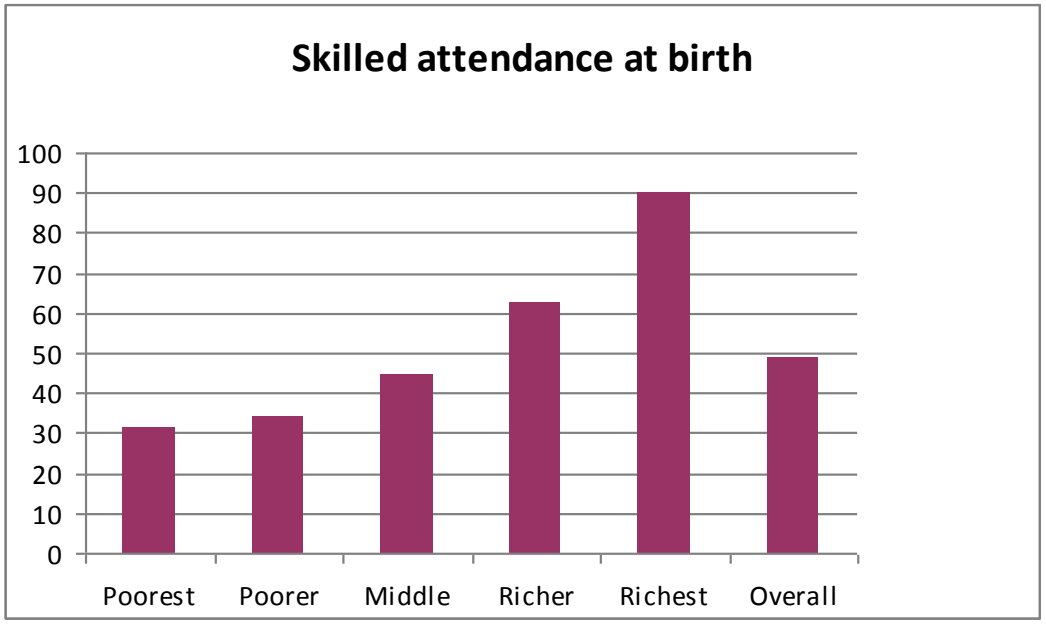
Privatization of facility births is increasing especially in Asia



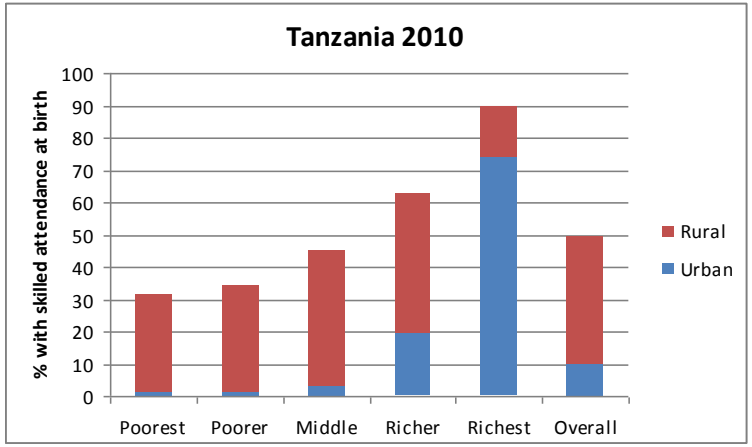
Pomeroy, Koblinsky, and Alva 2010

Nearly 50% of people (LMIC) live in urban areas!

Beware the quintile: Urbanization and the poor (Tanzania 2010)

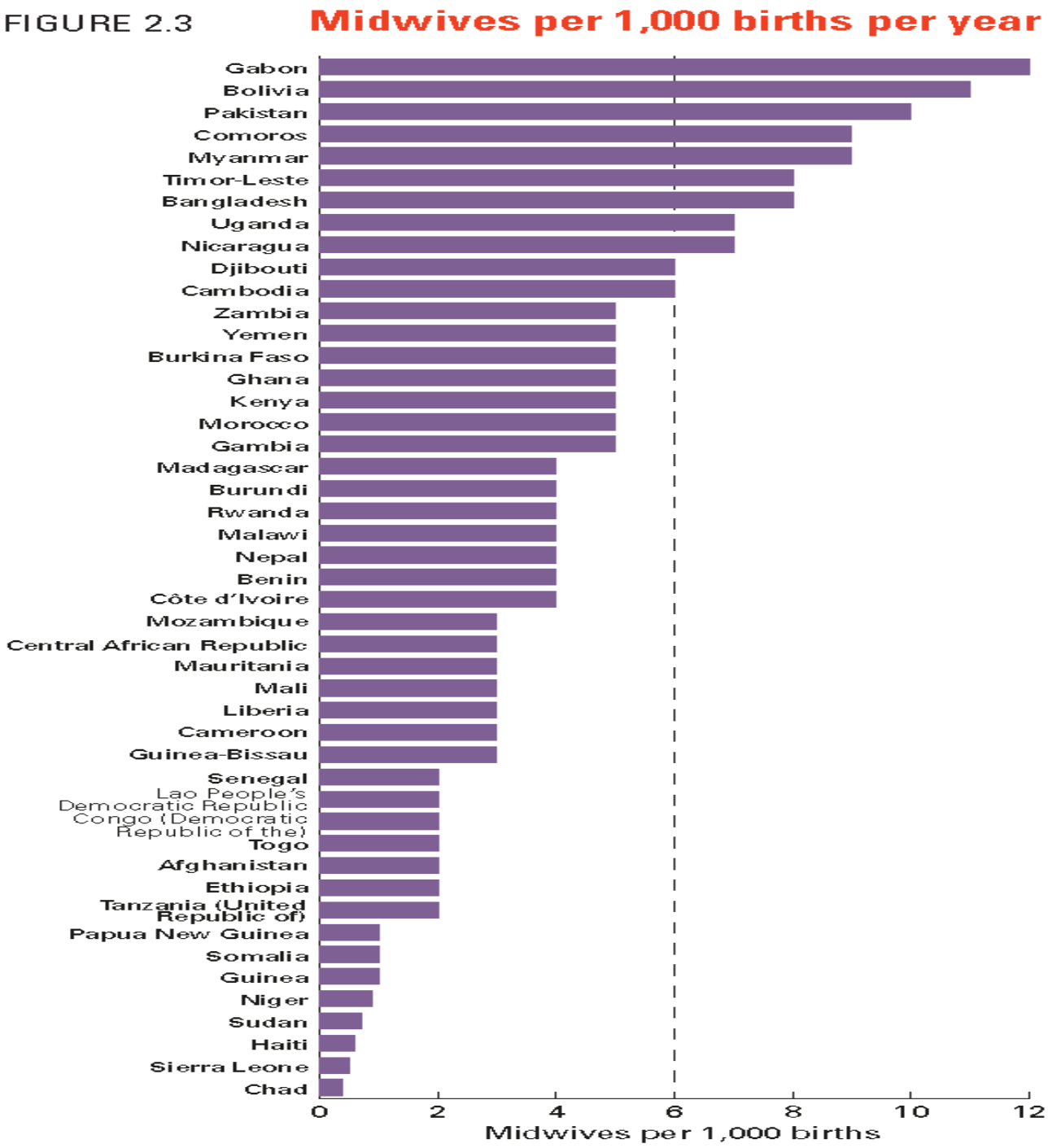


There is usually greater access to care in urban areas – but not among the poor



Matthews Z and Adanu R, 2013, Arusha

FIGURE 2.3


Midwives per 1,000 births per year
Gabon
Bolivia
Pakistan
Comoros
Myanmar
Timor-Leste
Bangladesh
Uganda
Nicaragua
Djibouti
Cambodia
Zambia
Yemen
Burkina Faso
Ghana
Kenya
Morocco
Gambia
Madagascar
Burundi
Rwanda
Malawi
Nepal
Benin
Côte d'Ivoire
Mozambique
Central African Republic
Mauritania
Mali
Liberia
Cameroon
Guinea-Bissau
Senegal
Lao People's Democratic Republic
Congo (Democratic Republic of the)
Togo
Afghanistan
Ethiopia
Tanzania (United Republic of)
Papua New Guinea
Somalia
Guinea
Niger
Sudan
Haiti
Sierra Leone
Chad
0
2
4
6
8
10
12
Midwives per 1,000 births

In summary….

1. Target setting—plausible/aggressive target (number or %), timing—by when
   - What to do re countries that have already reached target?
   - Is a flexible target more reasonable for countries that are far from the target?
   - Should we try to link maternal, newborn and child targets (meaning the 5 shifts)?

2. Reaching the target– Strategies based on local causes of maternal
   —More data needed
   - Epidemiology and demographics of maternal mortality
   - Integration of care for the causes
   - Demand for care
   - Infrastructure and quality of care

3. What contextual factors must be considered in the strategies?
   - Privatization of services
   - Financing initiatives
   - Decentralization
   - Urbanization
   - Subnational variables

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Many thanks

Financial Incentives – Generalized or Africa findings for delivery

Incentives	Effects
Performance based incentives	• Most show association with ↑ quality • DRC (small study) did not show association between PBI and institutional deliveries
Insurance	• Most show positive correlation with SBAs and facility delivery • 6 studies show positive correlation with C/S
User fee exemptions	• ↑ facility delivery rates • ↑ C/S rates, in some cases
Conditional cash transfers	• 6 studies show positive effect on birth with SBAs • 3 studies show positive effect on birth in a hospital
Vouchers	• Most show ↑ SBA or facility delivery

Source: Forthcoming PLoS Med Collection on Financial Incentives for Maternal Health Services