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Swiss Tropical and Public Health Institute
Schweizerisches Tropen- und Public Health-Institut
Institut Tropical et de Santé Publique Suisse

Medicus Mundi Switzerland

Symposium

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Successful Approaches to Improving Maternal and Newborn Health

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Swiss Centre for International Health

Outline

- Progress towards the MDGS
- What have we learned? Global progress, remaining challenges
- How can international health cooperation organisations more effectively promote maternal, newborn and child health?

The Millennium Development Goals

Eight Goals for 2015

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Millennium Declaration

In 2000, 189 nations made a promise to free people from extreme poverty and multiple deprivations. This pledge became the eight Millennium Development Goals to be achieved by 2015. In September 2010, the world recommitted itself to accelerate progress towards these goals.

1990-2015

Goal 1: Hunger and poverty

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Sustained growth in developing countries, particularly in Asia, is keeping the world on track to meet the poverty-reduction target

Proportion of people living on less than $1.25 a day, 1990 and 2005 (Percentage)

Robust growth in the first half of the decade reduced the number of people in developing countries living on less than $1.25 a day from about 1.8 billion in 1990 to 1.4 billion in 2005.

TARGET

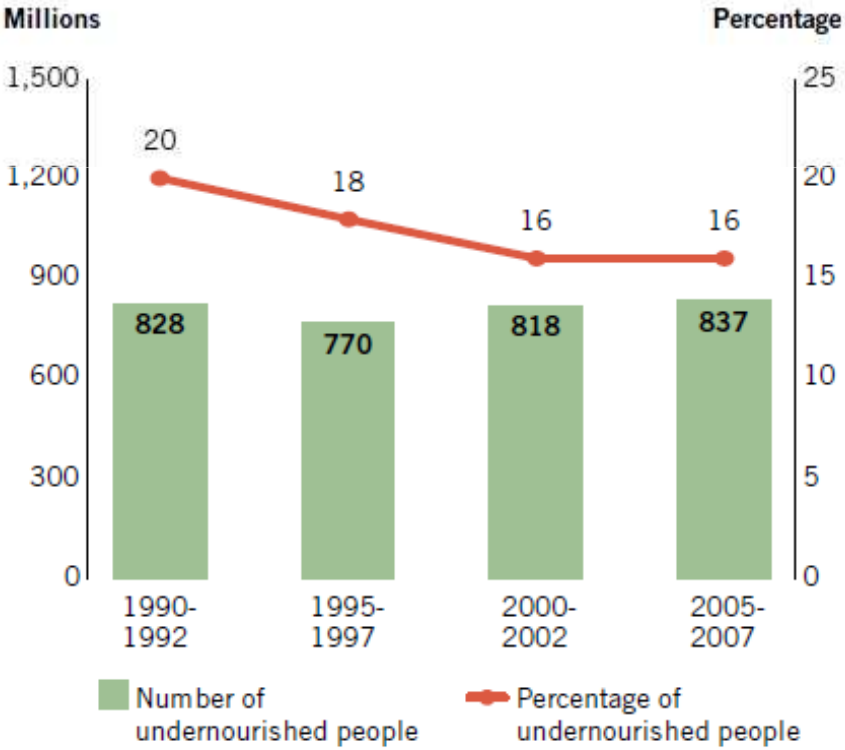
Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day

TARGET

Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

The proportion of people going hungry has plateaued at 16 per cent, despite reductions in poverty

Number and proportion of people in the developing regions who are undernourished, 1990-1992, 1995-1997, 2000-2002 and 2005-2007

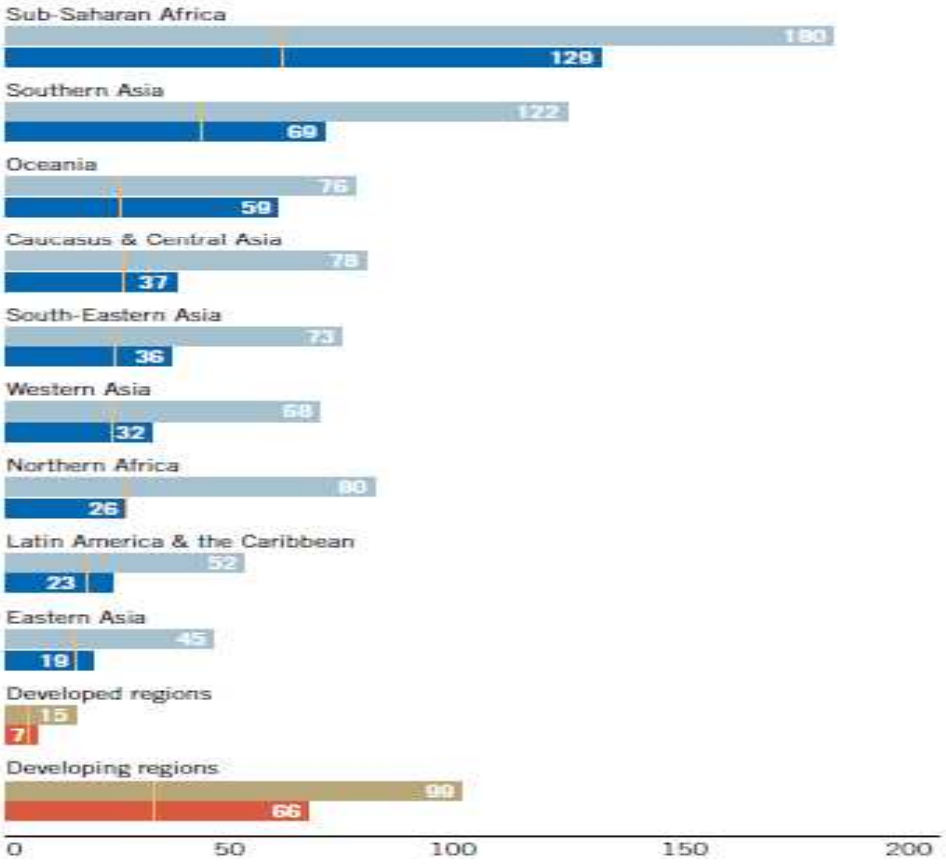


Goal 4 Child mortality

TARGET
Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Achieving the goal for child survival hinges on action to address the leading causes of death

Under-five mortality rate, 1990 and 2009 (Deaths per 1,000 live births)

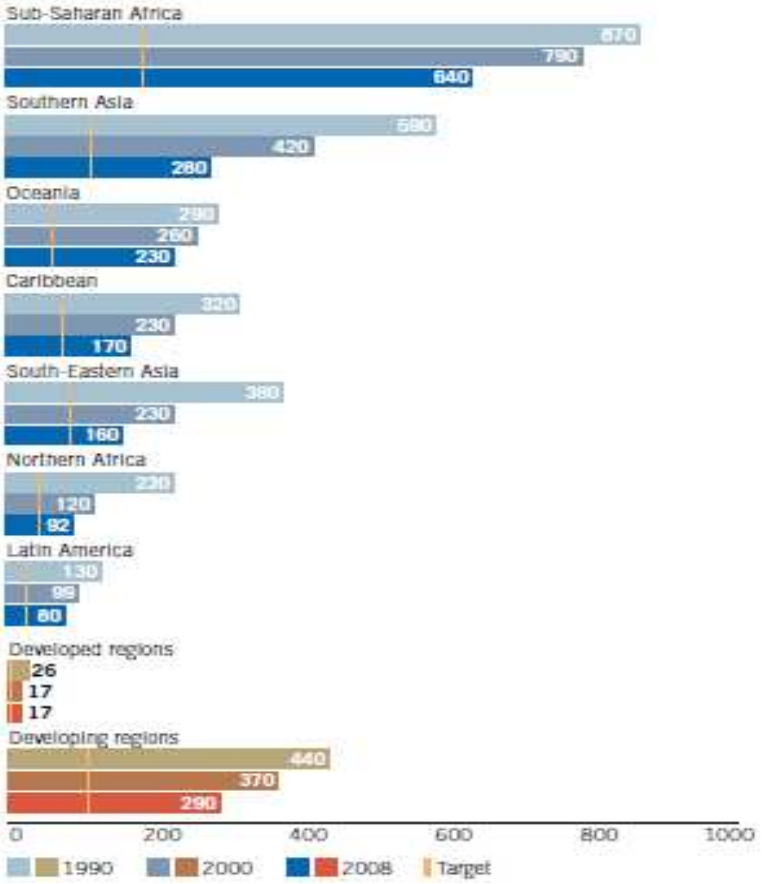


Goal 5:Improve maternal health

TARGET
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

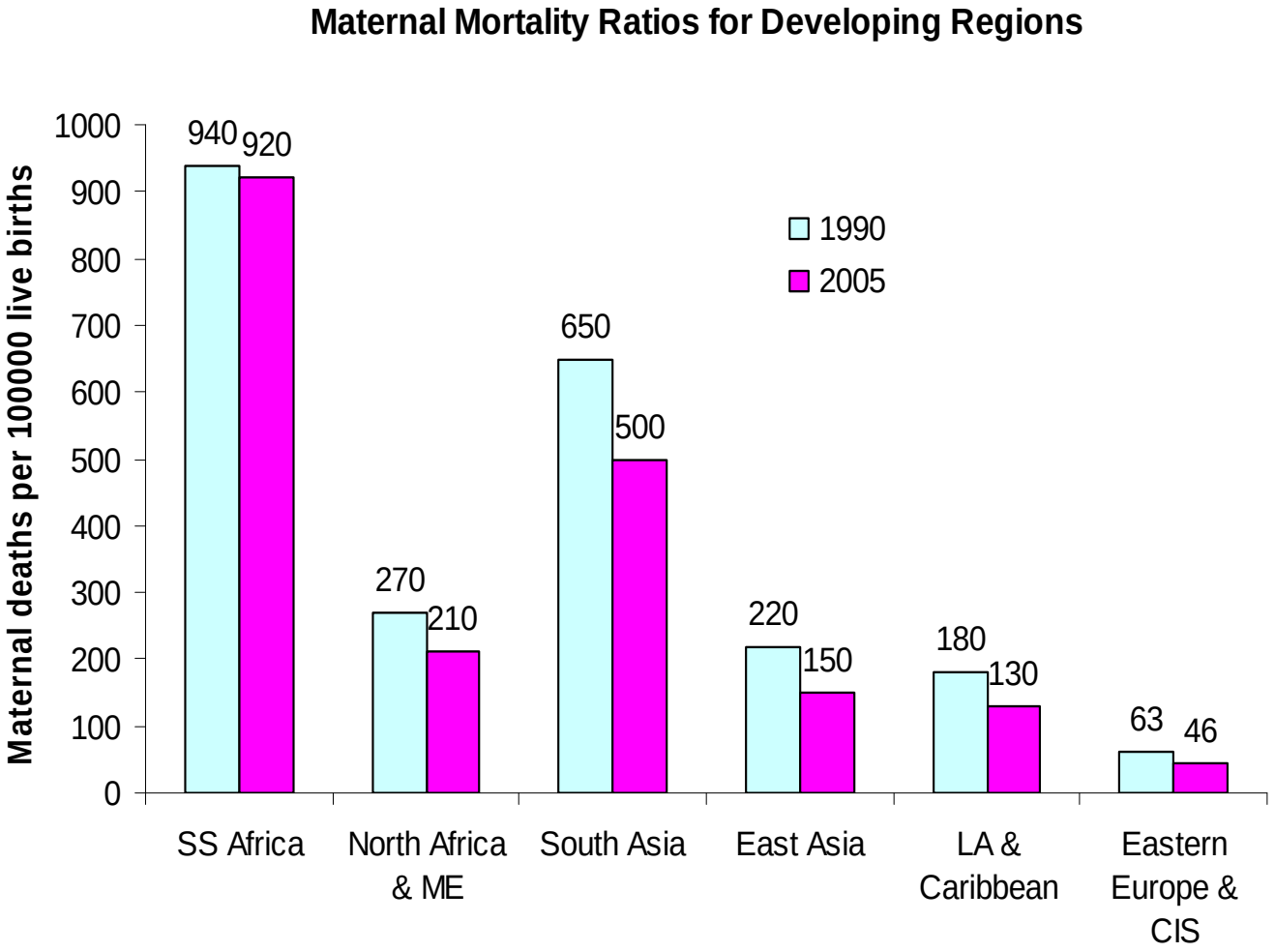
Despite progress, pregnancy remains a major health risk for women in several regions

Maternal deaths per 100,000 live births, 1990, 2000, 2008



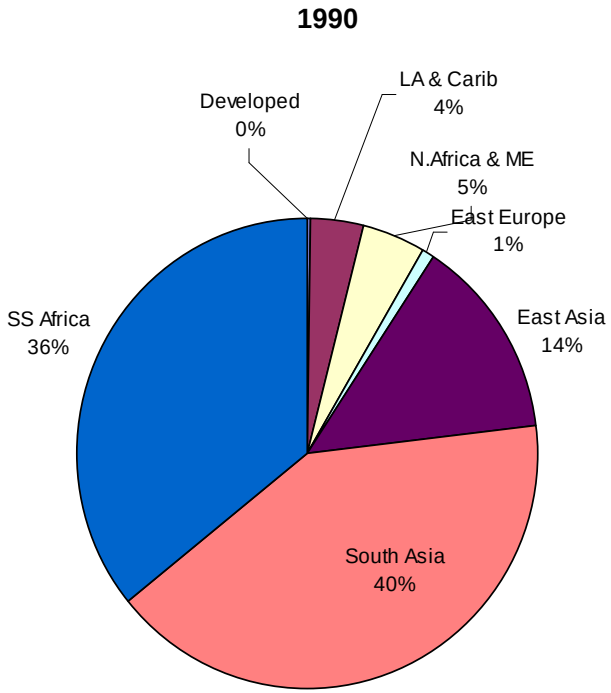
WHAT HAVE WE LEARNED ABOUT MATERNAL MORTALITY?

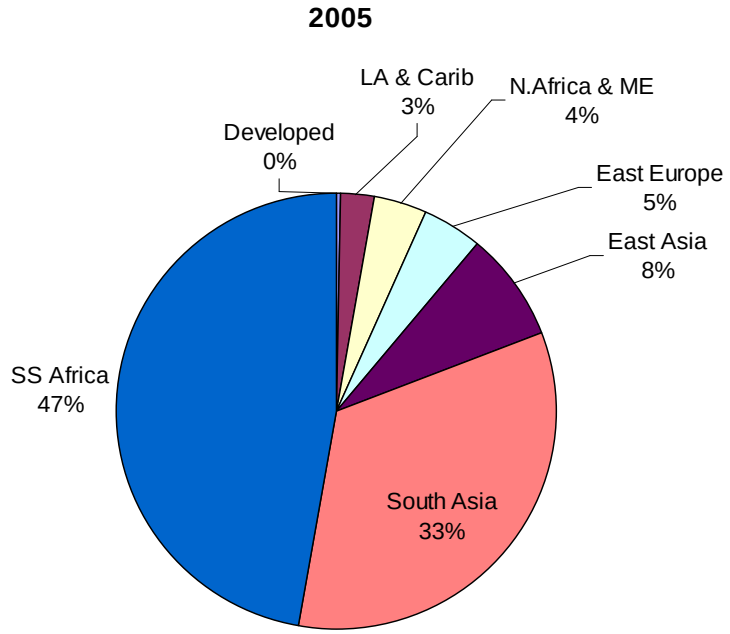
The Size of the Problem: Are Maternal Deaths a Rare Event?



Source of data: WHO, UNICEF, UNFPA & World Bank. Maternal Mortality in 2005.

Geographical Spread of Maternal Deaths in 1990 and 2005





Source of data: WHO, UNICEF, UNFPA & World Bank. Maternal Mortality in 2005.

Maternal mortality: New figures (2008)

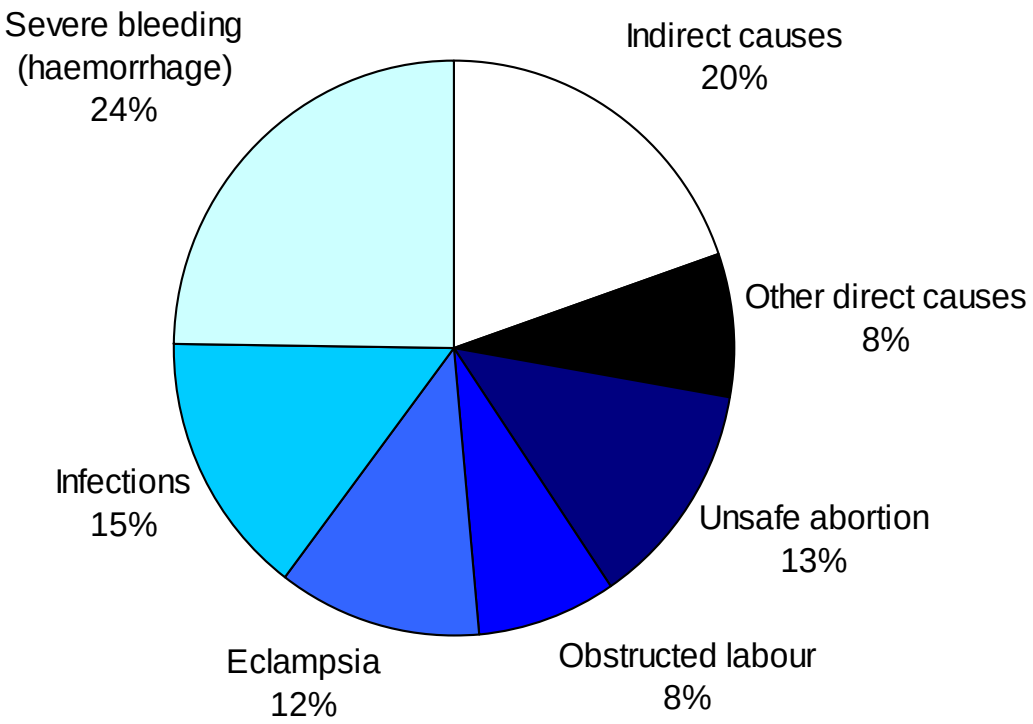
342 900 (uncertainty interval 302100–394300) maternal deaths worldwide in 2008 down from 526 300 in 1980

> 50% of maternal deaths in only 6 countries in 2008

India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo

MMR = maternal deaths per 100 000 live births

What Are Pregnant Women Dying From?



SOURCE: WHO World Health Report 2005. Making Pregnancy Safer.

Risk Factors for Maternal Death

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- Maternal age
- Parity
- Birth spacing
- Wantedness of pregnancy

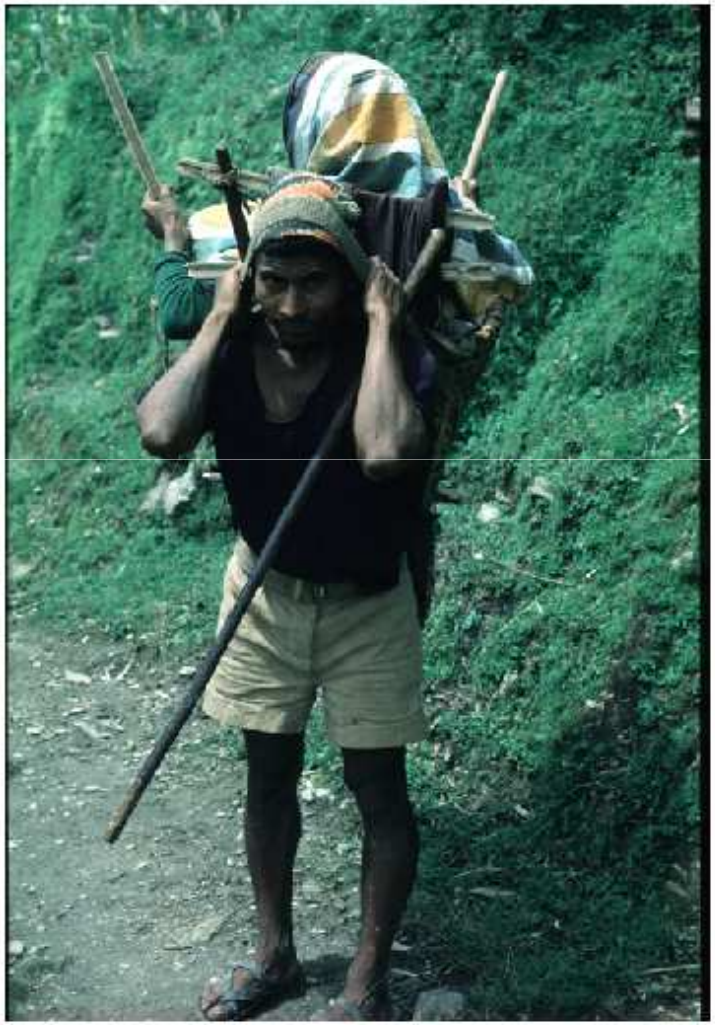
- Maternal mortality lowest at 20-24 years for second & third births
- BUT – these are not strong enough risk factors to use for planning – Every pregnancy faces risk

Four Delays

- Delay in recognition of the problem
- Delay in making a decision to seek care
- Delay in reaching appropriate care
- Delay in receiving care

Source: Thaddeus and Maine 1984

On the road



An ambulance!

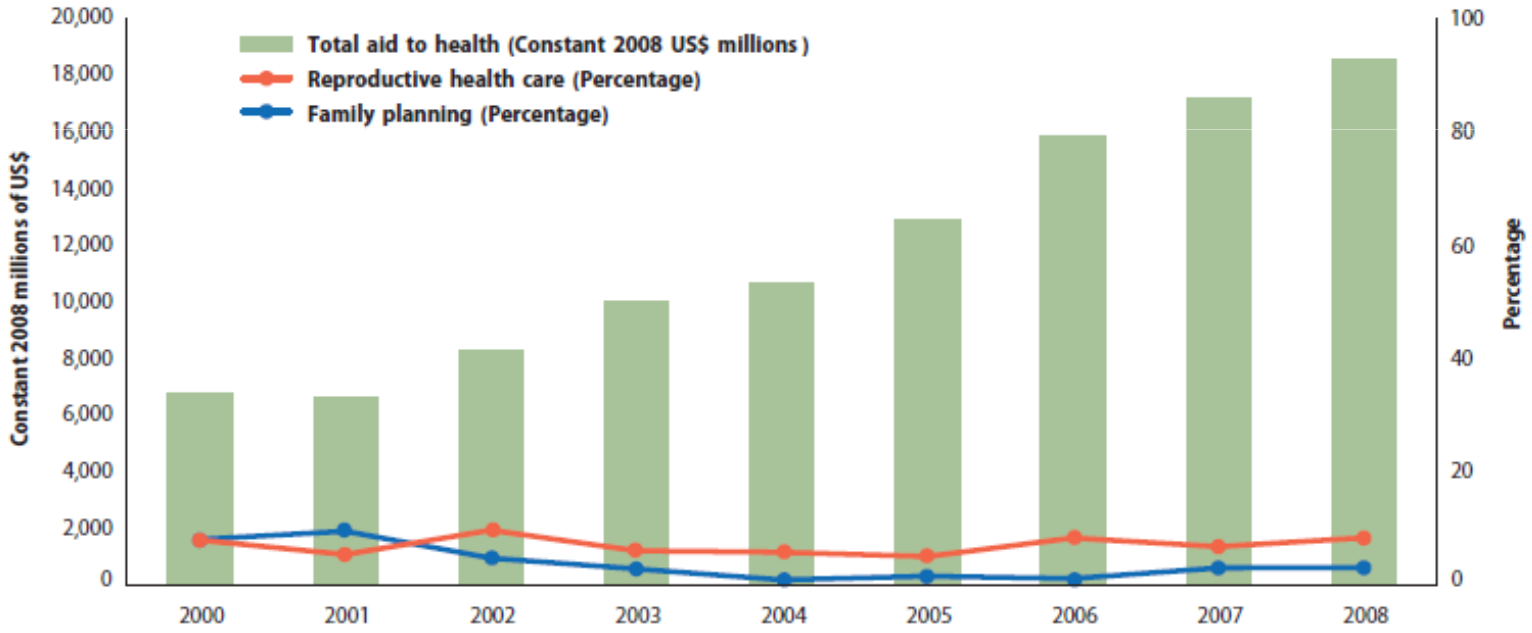
Very high maternal and infant death rates

Waiting for care

Where have we failed?

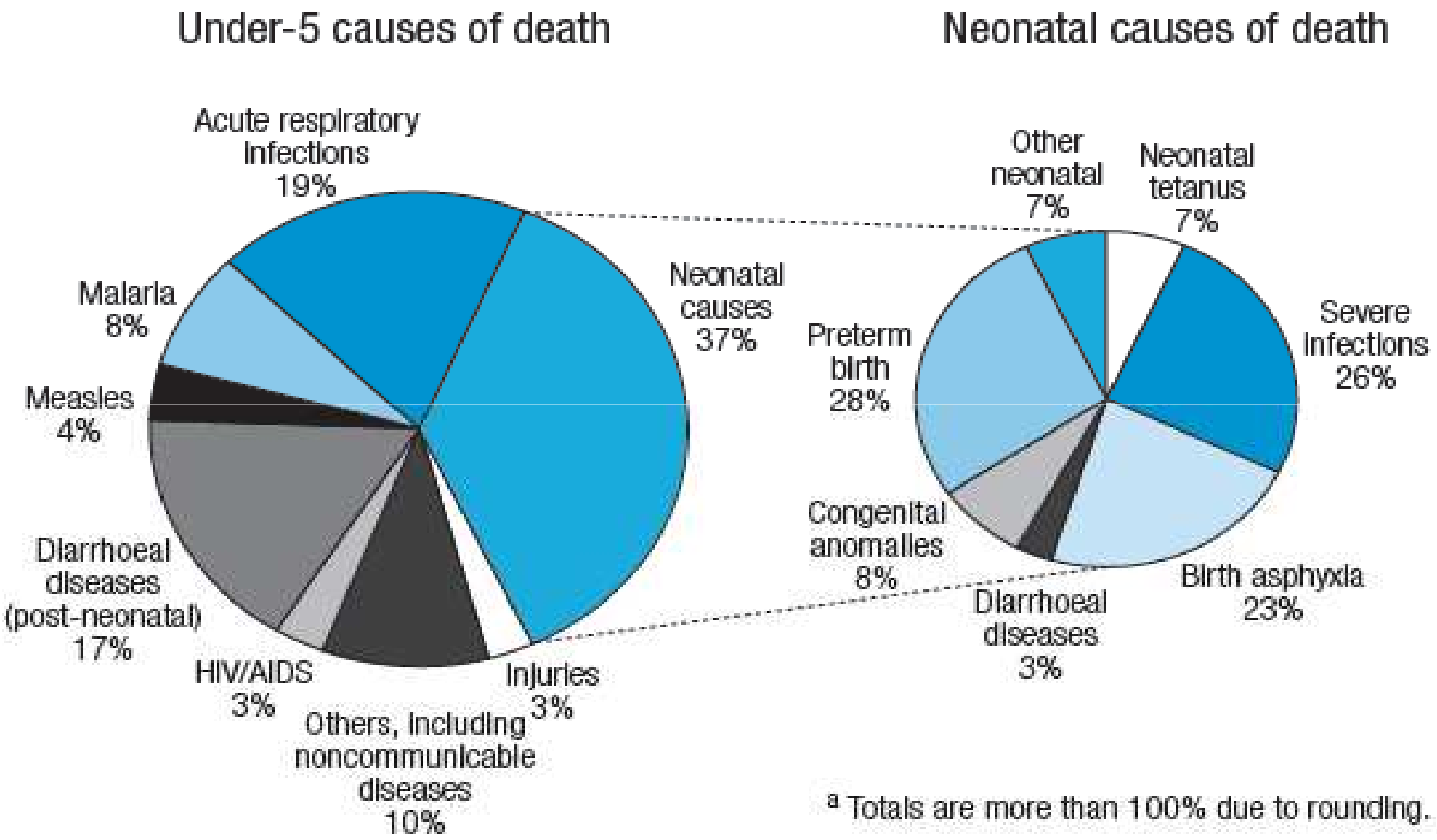
Inadequate funding for family planning is a major failure in fulfilling commitments to improving women's reproductive health

Official development assistance to health, total (Constant 2008 US$ millions) and proportion going to reproductive health care and family planning, 2000-2008 (Percentage)



WHAT HAVE WE LEARNED ABOUT CHILD AND NEWBORN MORTALITY?

What Do Children Die Of?



Newborn mortality – The Size of the Problem

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	NMR per 1000 livebirths (range across countries)	Number (%) of neonatal deaths (1000s)	Percentage of deaths in children aged younger than 5 years in the neonatal period	Percentage change in NMR between 1996 and 2005 estimates*
Income groups				
High-income countries†	4 (1–11)	42 (1%)	63%	−29%
Low-income and middle-income countries	33 (2–70)	3956 (99%)	38%	−8%
WHO regions				
Africa	44 (9–70)	1128 (28%)	24%	5%
Americas	12 (4–34)	195 (5%)	48%	−40%
Eastern Mediterranean	40 (4–63)	603 (15%)	40%	−9%
Europe	11 (2–38)	116 (3%)	49%	−18%
Southeast Asia	38 (11–43)	1443 (36%)	50%	−21%
Western Pacific	19 (1–40)	512 (13%)	56%	−39%
Overall	30 (1–70)	3998 (100%)	38%	−16%

*The data inputs cover at least a 5 year period before each set of estimates. Period of change may be assumed to be up to 15 years. †39 countries with NMR data of 54 countries with gross national income per person of >US$9386.[10]

Table 1: **Regional or country variations in NMRs and numbers of neonatal deaths, showing the proportion of deaths in children younger than age 5 years[1,9–11]**

When Do Neonatal Deaths Happen?

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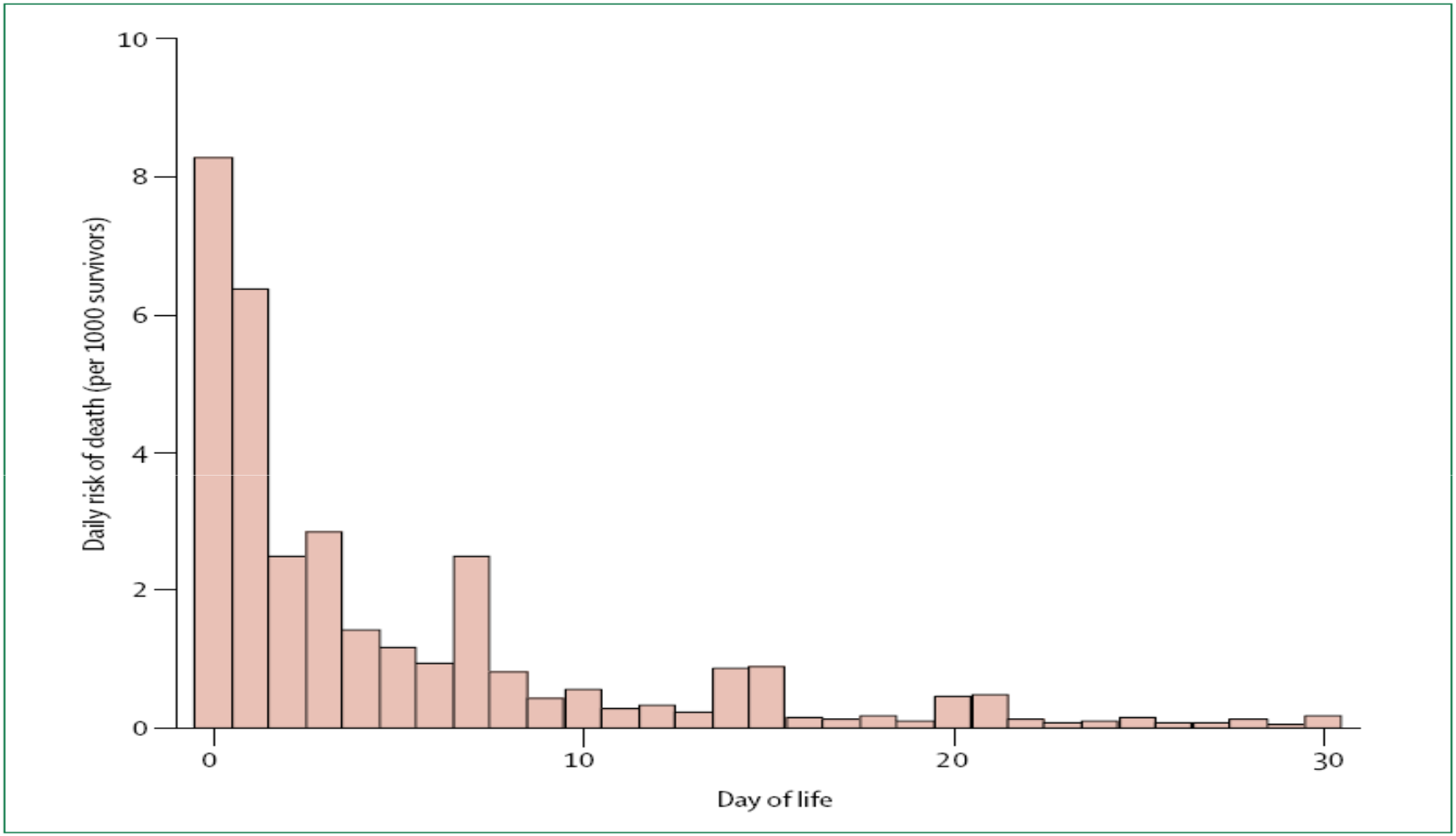

Figure 3: **Daily risk of death during first month of life based on analysis of 47 DHS datasets (1995–2003) with 10 048 neonatal deaths**

Deaths in first 24 h recorded as occurring on day 0, or possibly day 1, depending on interpretation of question and coding of response. Preference for reporting certain days (7, 14, 21, and 30) is apparent.

Neonatal Mortality

- Steady reductions in late neonatal mortality (7-28 days) down but slow progress in early neonatal period
- NMR declined by 28% but the proportion of child deaths in the neonatal period increased to 41%
- Maternal health complications contribute to 1.5 million neonatal deaths during the first week of life; 1.4 babies are still born.
- Evidence based MNH interventions will reduce MMR, NMR, and the under 5 Child mortality.

[Ref: ZA Bhutta et al. Reducing maternal, newborn and infant mortality globally: an integrated action agenda. IGOG 119 (2012) S13-17.]

Dead Ends and Roads to Success

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What hasn't worked

- Antenatal risk screening
- Training Traditional Birth Attendants (TBAs)
- Sitting back and waiting until poverty 'disappears'

What has worked

- Continuum of care from home to hospital
- Use of professionals – 'skilled attendants'
- Rolling out midwifery care and hospital care simultaneously
- Accountability of health care
- Strong role of state – political commitment
- Safe abortion
- Flexible funding

Renewed Emphasis on SBA

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What is a skilled attendant?

A skilled attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns

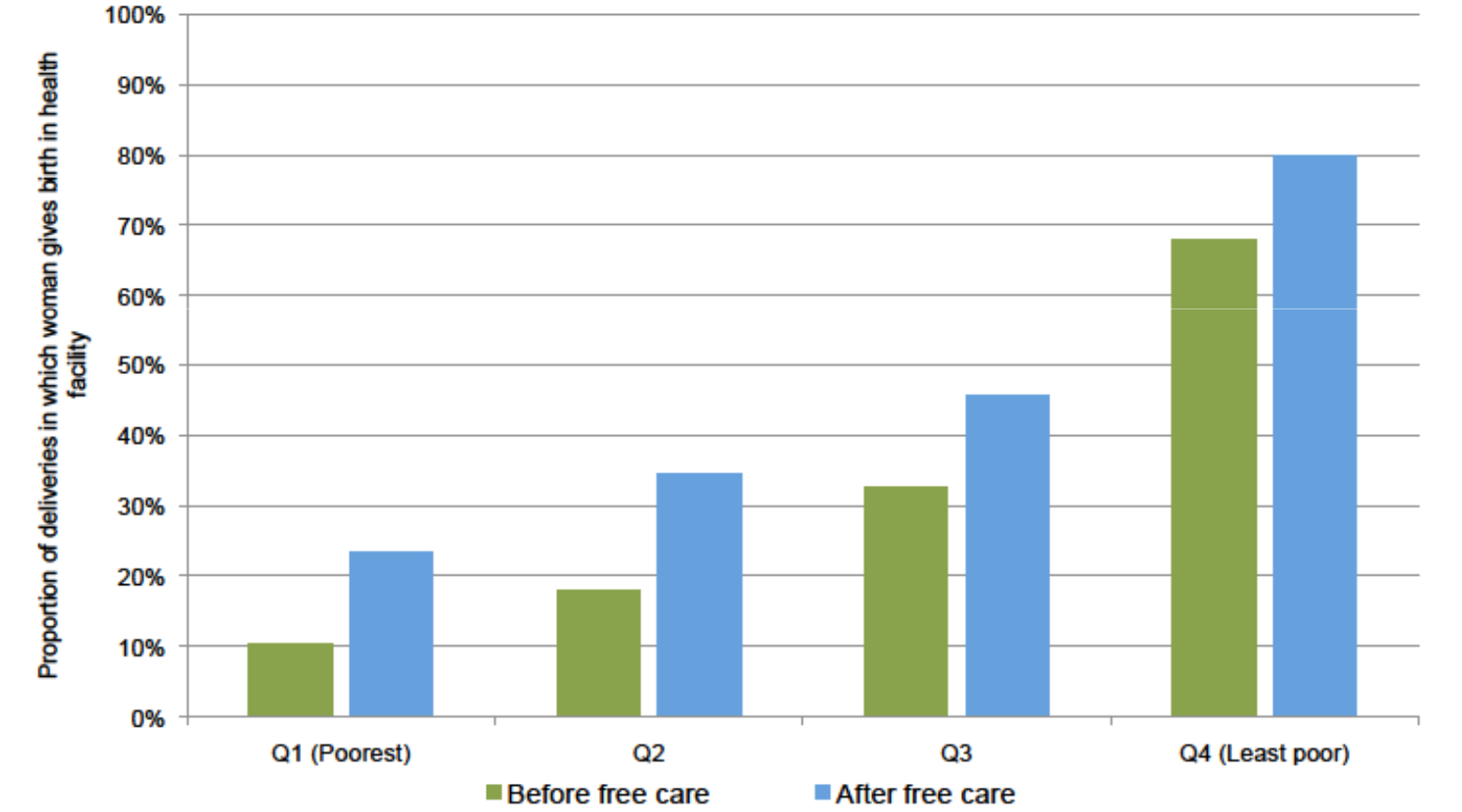
Renewed Emphasis on SBA

- Only 43% of pregnant women receive at least some care during pregnancy in the developing world (taking the 75 countries that contribute 95% of the worlds deaths)

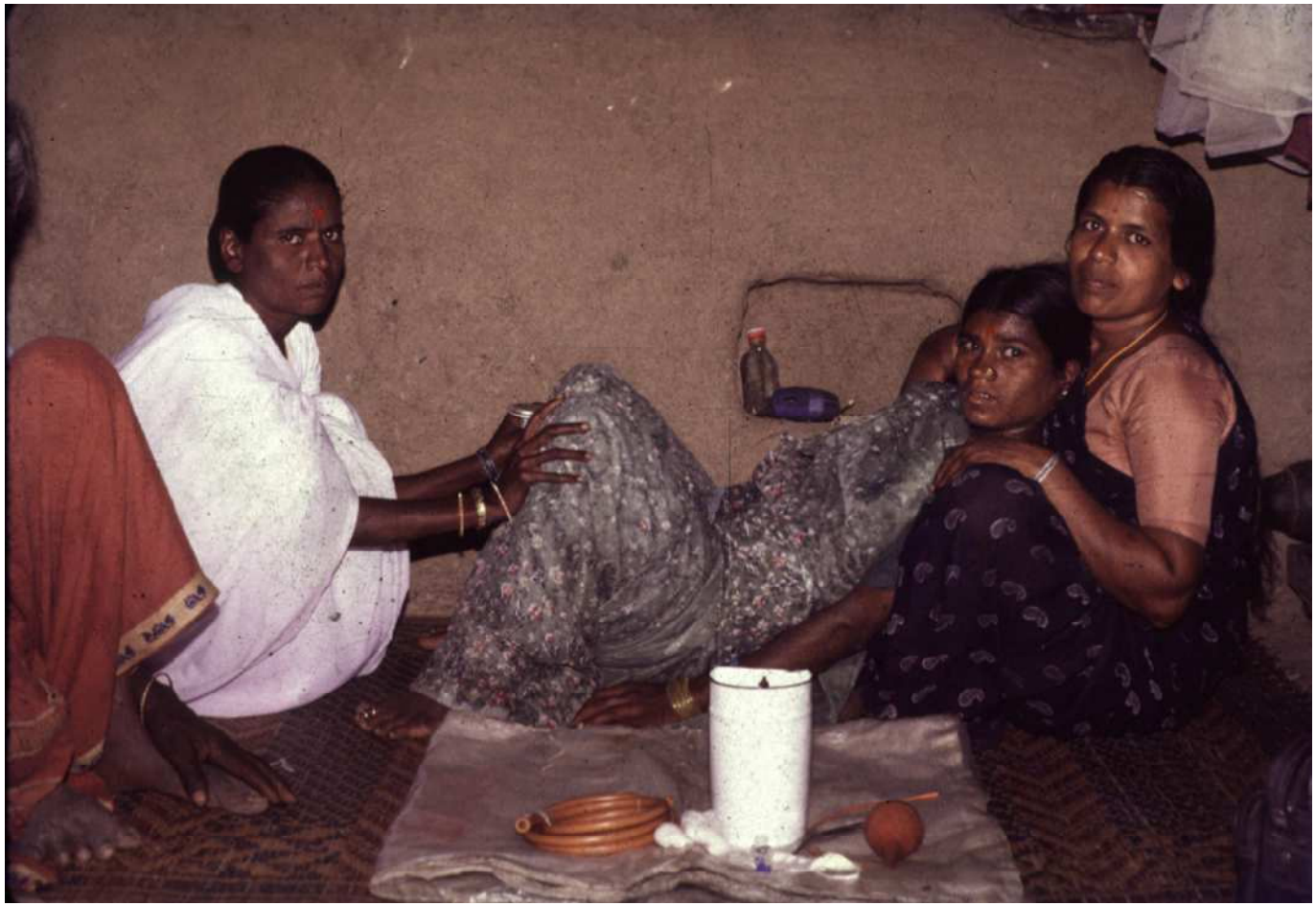
- Skilled personnel assist in slightly more than half of all deliveries
  - 35% in South Asia
  - 41% in SSA
  - 80% in East Asia, Latin America & the Caribbean

Access to care

Inequality in utilisation of delivery care services has fallen with the introduction of free delivery care



Maternity incentives: conditional cash transfers



Nepal, Ghana, India

Understand the context

What can we do?

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10 useful tips for

MNCH programme managers

1. Understand the local population

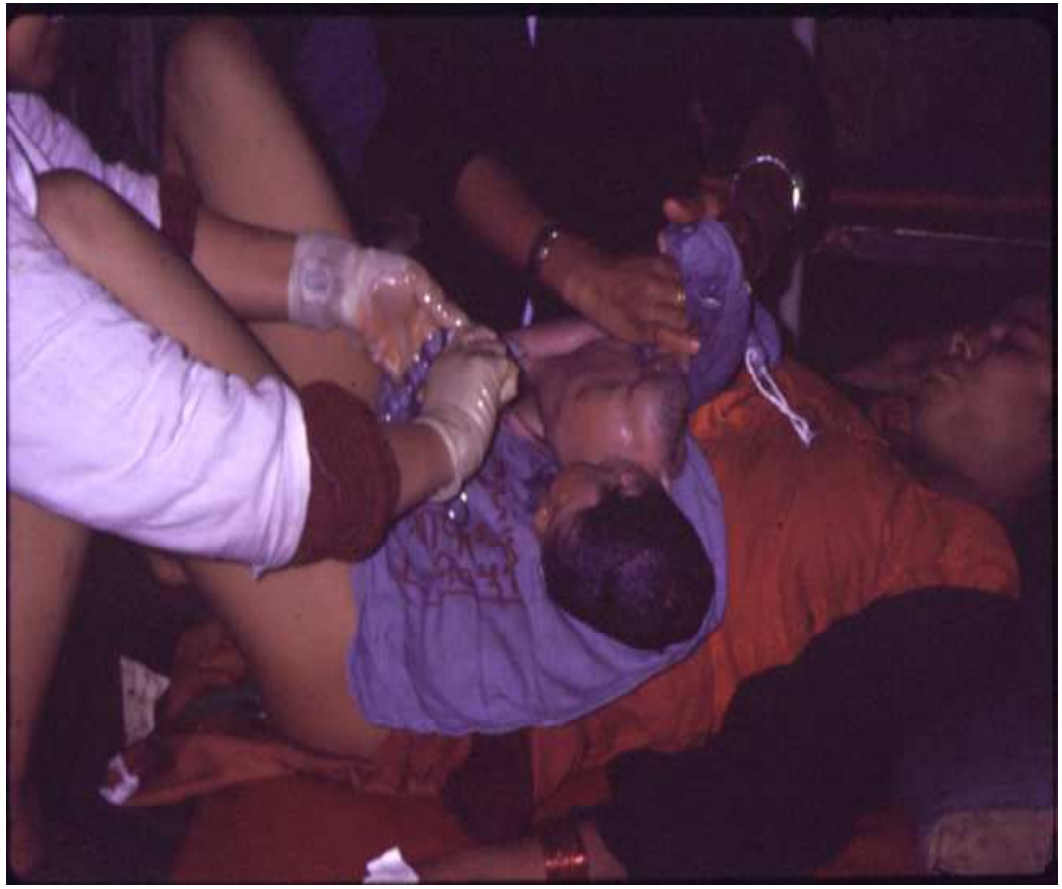
- Size and demographic profile
- Social and economic status and equity
- Culture and ethnicity

1. Understand the local population

- Development status
- Status of women
- Urban/rural balance
- Effect of seasonality
- Migration patterns

2. What are the needs and priorities for MCH care?

- Basic curative services
- Antenatal care
- **Delivery care**
- Essential care of the newborn
- Breastfeeding support
- Immunisation
- Nutrition education and rehabilitation



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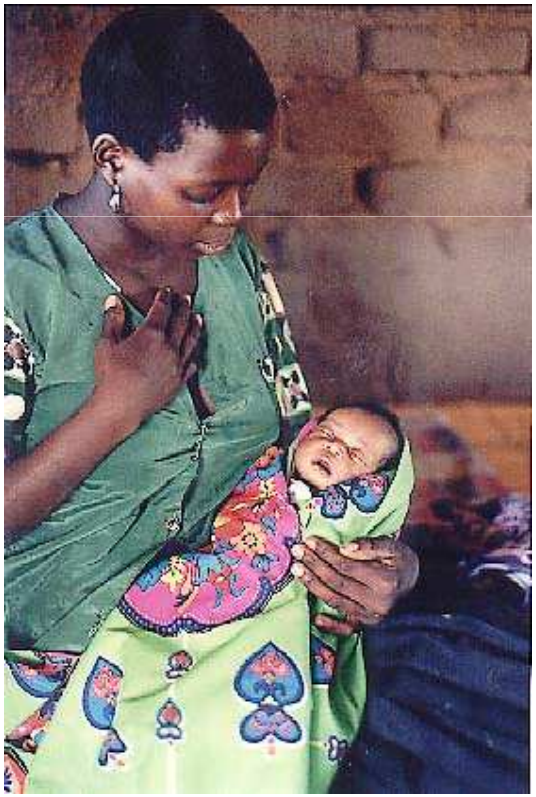

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3. Analyse your resources in detail

- Staff
- Cash
- Supplies/drugs
- Community input
- Cost-recovery

4. Review the links between primary and secondary levels of care

- Resource allocation
- Referral
- Supervision and training

5. Develop ownership and participation

- Community leaders
- Mothers groups
- Fathers
- Primary and secondary level staff
- Real democracy – avoid tokenism
- IEC

6. Spend time on planning

- Six monthly plans
- Job descriptions
- Appraisal and peer review
- Calendars of activities...but flexible
- Time management
- Staff development and team building
- Incentives
- Budgetary discipline

7. Discuss how to provide a quality service

How far do your services comply with the following criteria?

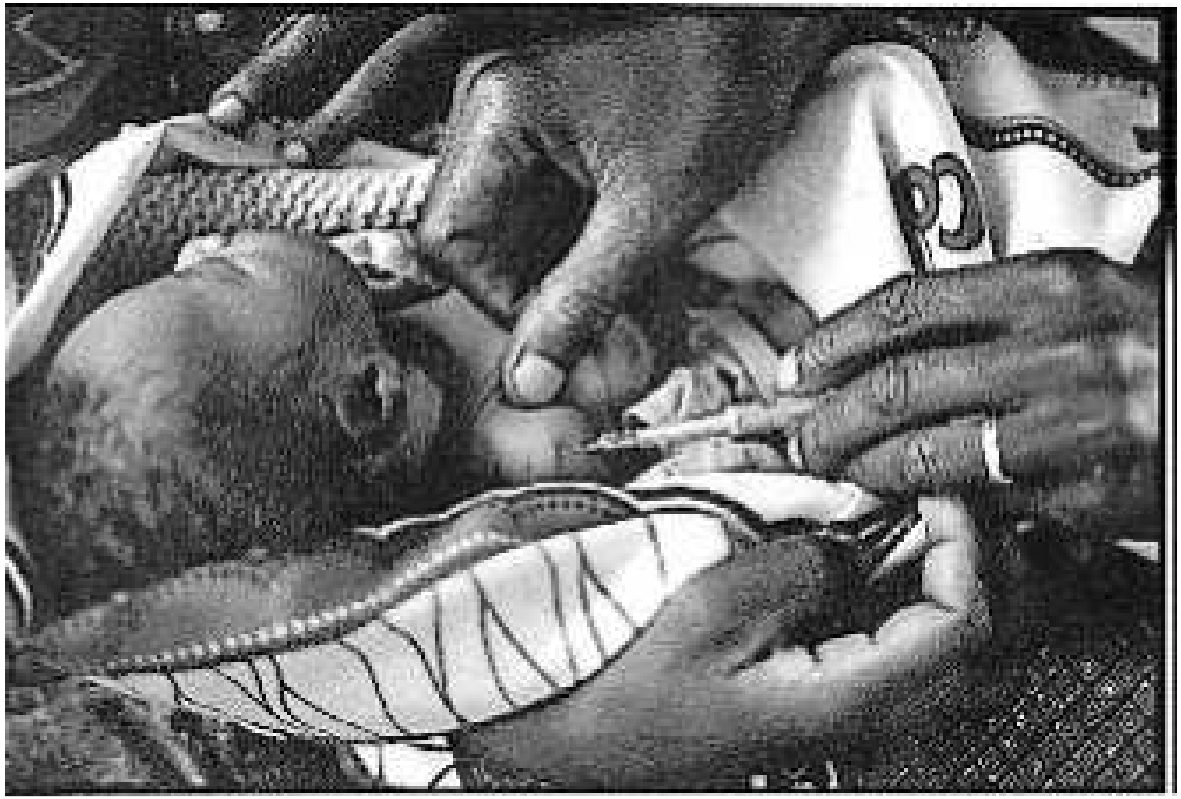
- Relevant to need
- Effective
- Efficient
- Accessible
- Acceptable
- Affordable
- Equitable

8. Troubleshoot to maintain quality

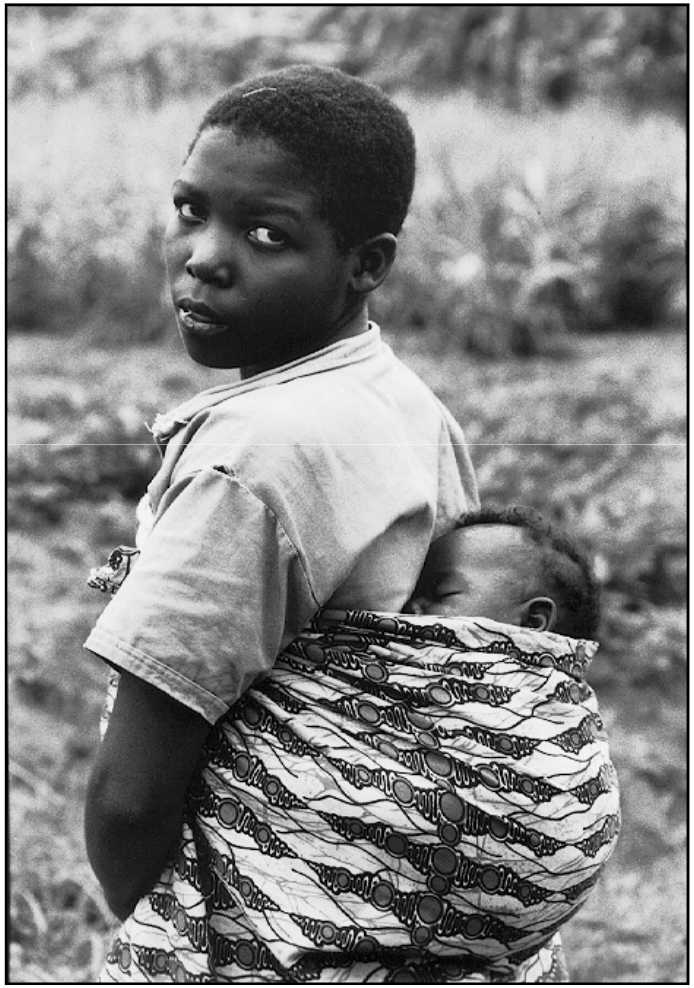
- Participation and dialogue
- Audit to monitor quality indicators:
  - structure
  - process
  - outcome

9. Are services sustainable?

- Beware of outside resources and dependence
- Hidden costs especially in NGOs
- Lethargy



10. Consider your role as an MNCH advocate



- For resources
- For staff development
- For health promotion
- For women and children's rights
- For people in difficult circumstances

What else should we do?

Donors:

- Ensure ODA targets social programming that works
- Work in **partnership** and harmonise with other donors / H4+ to ensure synergies and reduce ineffiencies
- Support governments to **strengthen sustainable health systems**

International NGOs:

- Ensure projects are in-line with government priorities and approaches
- Support **capacity building** of national and sub-national policy makers/managers to implement priority interventions
- **Know your niche**; and partner in country (and internationally) for areas where you don't have the expertise.
- Leave behind sustainable investments

THANK YOU!!