THE ROAD MAP AS THE REGIONAL STRATEGY FOR ACCELERATING THE REDUCTION OF MATERNAL AND NEWBORN MORBIDITY AND MORTALITY IN AFRICA

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INTRODUCTION

Maternal Mortality and Magnitude of the problem

Global Statistics

- 180–200 million pregnancies per year.
- 75 million unwanted pregnancies.
- 50 million induced abortions.
- 20 million unsafe abortions (same as above).
- 585,000 maternal deaths (approximately 1 per minute)
- 1 maternal death = 30 maternal morbidities
- Annually, 585,000 women die of pregnancy-related complications with 99% occurring in the developing world and approximately 1% in developed countries.

Nigeria Statistics

- Maternal Mortality Ratio (MMR) is 800 - 1100/100,000 live births equating to estimated annual absolute maternal death of 54,000; 9% of world total maternal death figure (second to India).
- Life time risk of dying from complications of pregnancy and childbirth: 1:18.
- There is a wide variation in MMR across geo-political zones of Nigeria; lowest in the South West (400/100,000) and highest in the North West at over 1800/100,000.
- Approximately 60% of Nigerian pregnant women have access to prenatal care.

Magnitude of Maternal Mortality in Nigeria – Questions Raised

Is the magnitude of maternal mortality in Nigeria:

- Still just a problem?
- An intractable, unrelenting problem?
- Have we not reached a CRISIS?
- Can we learn from experience with reduction observed in infant/childhood mortalities?

"The ROAD MAP" as the Regional Strategy for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Africa

- 2003 Regional (WHO-Afro) Reproductive Health Taskforce meeting called all partners to develop and implement a Road Map for accelerated maternal and newborn mortality reduction in Africa.
- 16-18 February 2004: Partners' meeting to develop the Road Map held in Harare, Zimbabwe.
- The Road Map was jointly developed by WHO and 18 partners with an interest in improving maternal and child health in the Region.

OBJECTIVES

General Objective

To accelerate the reduction of maternal and newborn mortality towards the attainment of the MDGs in Africa.

Specific Objectives

1. To provide skilled attendance during pregnancy, childbirth and postnatal period at all levels of the health care delivery system;
2. To strengthen the capacity of individuals, families, and communities to improve MNH.

Strategies for Attaining the Objectives

Improving provision of, and access to, quality maternal and newborn care services, including family planning services;
Strengthening the referral system;
Strengthening district health planning and management of maternal and newborn health care and family planning services;
Advocating for increased commitment and resources for maternal and newborn health care and family planning services;
Fostering partnerships;
Promoting the household to hospital continuum of care; and
Empowering communities.

Some Important Features on the Road Map

Fostering strategic partnerships (Governments, Bilateral Agencies, NGOs, Community).
Mobilization/ Advocacy for funding

towards implementation.

Country-specific Road Maps were developed.

Emphasis on:

- Skilled Attendance at Delivery
- EmOC, Evidence-based/Best Practices, Quality M & E
- Strengthening the Referral System
- Continuum of care at family/community levels
- Capacity Building

No wheels are reinvented.

MONITORING AND EVALUATION

Indicators were selected for the different levels of care and services to be delivered.

Phased implementation

- 2004 – 2009
- 2010 – 2014
- 2015 – reporting year for the MDGs

MTR and end of implementation evaluation.

Monitoring the progress of the Road Map at regional level.

THE ROAD MAP – SUCCESS STORY

- The Road Map was successful in building strategic partnerships for MNH.
- The Road Map encouraged/facilitated country level strategic planning, implementation and monitoring.

What is '*REDUCE*'?

- An advocacy tool that can be used to stimulate and/ or mobilize policy makers to dialogue and initiate strategic planning for appropriate actions to reduce maternal and new-born illnesses and deaths.

Interactive computer models are used; from existing data e.g. (MMR, CMR) current status and intervention impact of appropriate actions are estimated (Fig. 1).

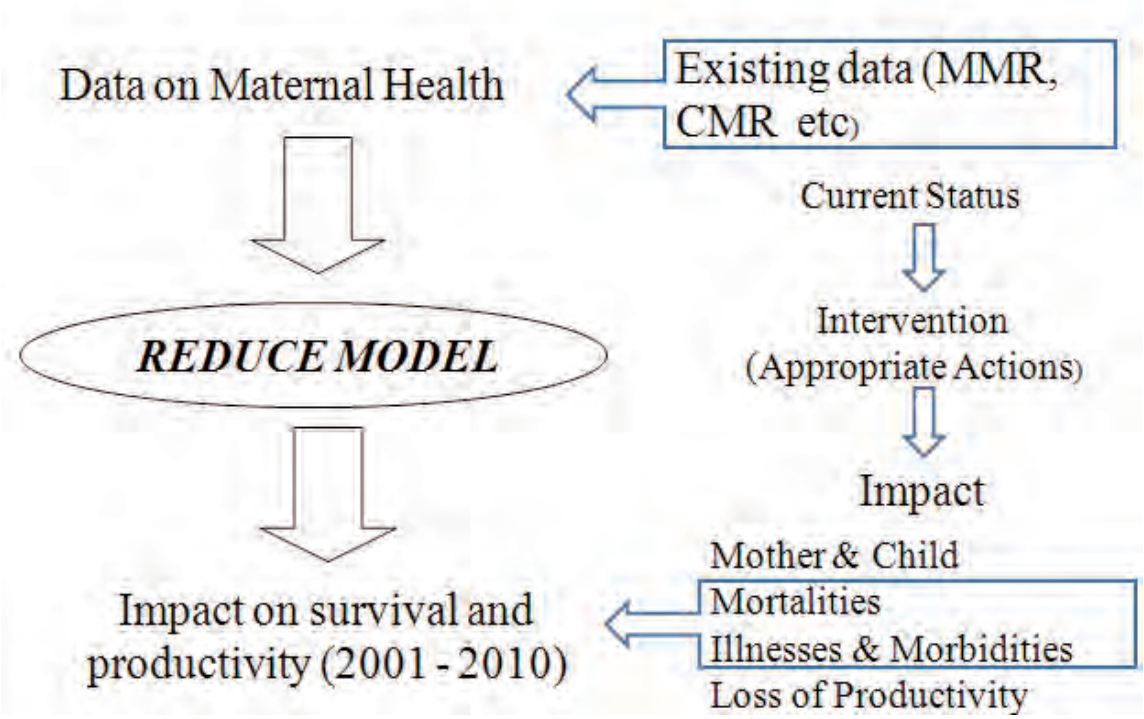


Fig. 1: Estimating the Consequences of Poor Maternal and Newborn Health (I)

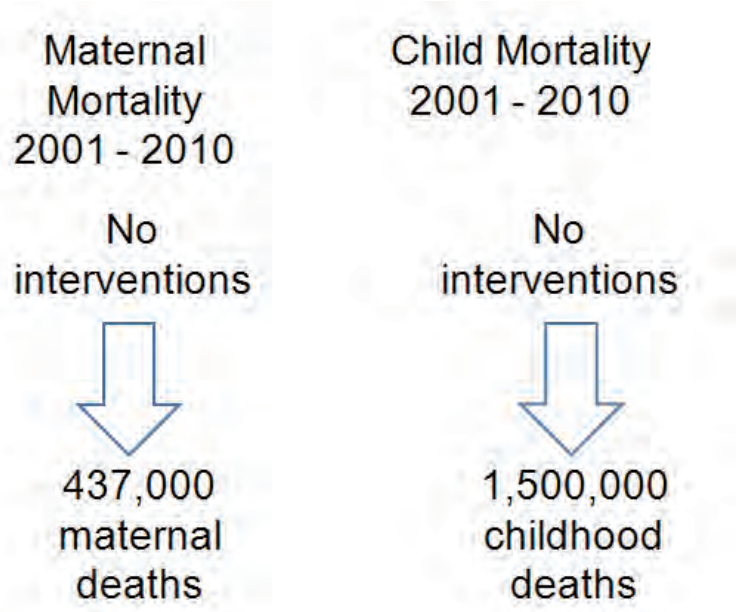


Fig. 2: Estimating the Consequences of Poor Maternal and Newborn Health (II)

COMMITMENT TO REDUCING MATERNAL AND NEWBORN DEATHS

Interventions

- Implement existing policies.
- Strong political commitment.
- Allocate & release 15% Tb to health; 10% of this to Reproductive Health.
- Ensure partnerships.
- Capacity building and incentives.
- Free treatment of all obstetrics emergencies.
- Improved facilities.
- Basic and Comprehensive EmOC facilities (as per UN process indicators) etc.

The Gains If We Act Now

- 108,000 women's lives saved.
- 2,000,000 disabilities averted.
- 340,000 children's lives saved.
- $ 536 million (61 billion naira) in productivity gains.

Other Landmark Strategic Plans, Actions, Conferences/Congress

1974 - Alma Ata (HFA by 2000)

1987 – Safe Motherhood Initiative

- 1994 – Cairo; International Conference on Population and Development
- 1995 – Beijing Fourth World Congress on Women

2000 - Safer Pregnancy Initiatives: (Lessons Learned from Safe Motherhood)

- UN Process Indicators
- Averting Maternal Deaths and Disabilities (AMDD)
- WHO "Beyond the Numbers"

United Nations Millennium Development Goals (MDGs)

1998 - 2007 Reproductive Health Strategy for the African Region – Strategic framework with objectives and targets.

Nigeria IMNCH (Integrated Maternal, Newborn and Child Health Strategy)

SOGON National Partnership Plan for Sustainable Reduction in Maternal & Newborn Deaths in Nigeria

"How Far Have We Gone?" or "Where Are We?" or "Why Are We Where We Are?"

Maternal Mortality Ratio per 100,000 live births: 450-1700 (Average 800)

Contraceptive Prevalence Rate: 13%

Antenatal Care Coverage:

- At least one (1) visit: 58%
- At least four (4) visits: 47%
- No antenatal care: 37%

Health facility (Institutional) births: 33%

- Skilled Attendant at Delivery: 35% (rural 27.1%, urban 58.8%)

Percentage Emergency Obstetric Care (EmOC) Facilities (based on UN Process indicators: 5 -10%

Strength and Weakness Analysis

STRENGTH

Strength -1: The causes of maternal mortality are known and these have not changed (Fig. 3)

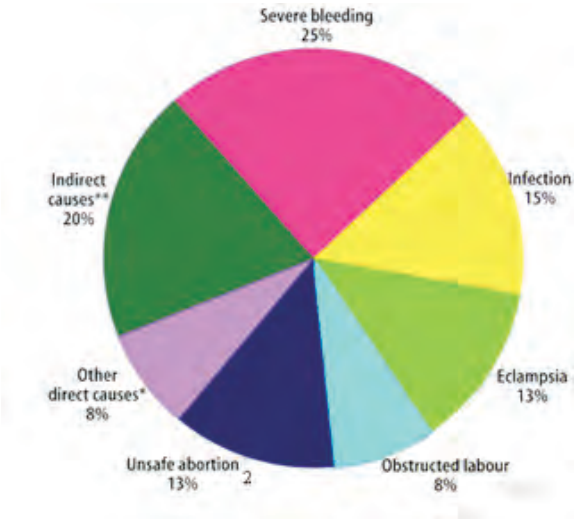
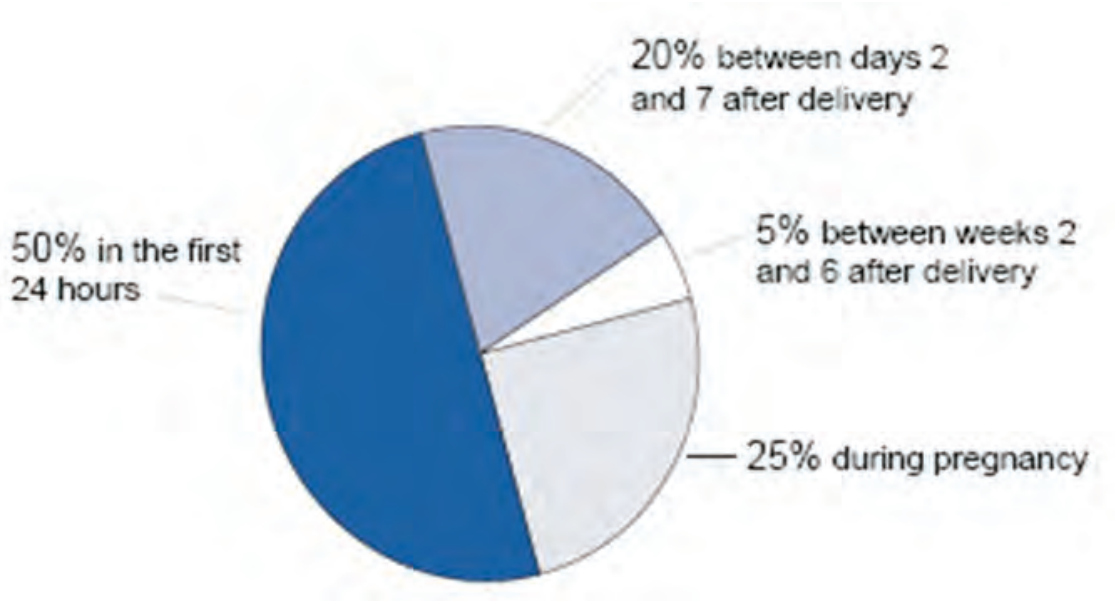


Fig 3. Causes of Maternal Deaths

Strength -2: The timing of maternal deaths and morbidity are well known (Fig. 4).



Source: UNICEF

Fig. 4: Timing of Maternal Death

Strength -3: T**he medical and social strategies critical to reducing maternal mortality and morbidity are also well known (Fig. 5).**

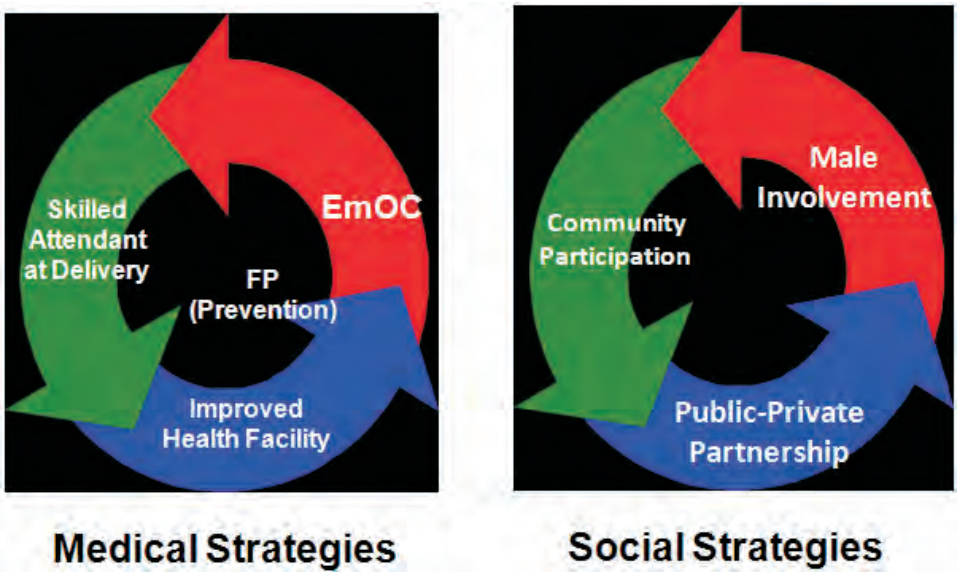


Fig. 5: Medical and Social Strategies Critical to Reducing Maternal Mortality and Morbidity.
Strength -4: Nigeria has a reasonable number of skill mix critical to reducing maternal mortality and morbidity (Table 1).

Table 1: Number of Some Categories of Health Workers in Nigeria 2006

Staff Type	Number of Staff	No. of Staff/100,000 population
Doctors	39,210	30
Nurses	124,629	100
Midwives	88796	68
Dentists	2,773	2
Pharmacists	12,072	11
Medical Lab. Scientists	12,860	12
Community Health Practitioners	117,568	19
Physiotherapists	769	0.62
Radiographers	519	0.42
Health Record Officers	820	0.66
Environmental Health Officers	3441	3

Source: National Health Resources for Health Policy 2006

Strength -5: Nigeria has a reasonable number of health facilities in most parts of the Federation. Each State of the Federation has one tertiary health institution (either a Teaching Hospital or a Federal Medical Centre [Only Edo State had two]). As at 2001 there were 15 Teaching Hospitals, three Orthopaedic hospitals, eight (8) Neuro-psychiatric Hospitals, 23 Federal Medical Centres, one (1) National Eye Hospital, one (1) National Ear Care Centre and one (1) National Hospital, Abuja.

WEAKNESSES (TOO NUMEROUS)

- Weak political will – rhetoric, grandstanding, little/no action.
- Weak health and infrastructural facilities.
- Lack of monitoring and evaluation.
- Poor funding.
- Poorly coordinated efforts.
- Non-accountability for failed efforts.
- Shifting Goals/Strategic Plans.
- Conference/Meeting supports for those not present where maternal mortalities occur.
- Poor efforts at capacity building.
- And many others.

Traditional Birth Attendants – Arguments for Exclusion

A. "The Golden Hour and the Silver 6 hour": The"4th Stage of Labour (first 24hrs) accounts for 50-60% of all maternal deaths.

B. Strategies that work:

1. Intrapartum care a priority.
2. Health-centre delivery by a skilled attendant.
3. EmOC

C. TBAs are available every part of the country and many.

1. What do we do with them?

INFANT AND UNDER-5 MORTALITY

There is some evidence to show that Infant and Under-5 Mortality Rates in Nigeria are on the decline (Table 2 & Fig. 6). This is because the causes of infant and childhood mortalities are largely preventable and amenable to known child survival strategies.

Table 2: Comparison of Infant and Under-5 Mortality Rates between 1999 and 2003

Indicators	1999 DHS	2003
Infant Mortality Rate	75/1000 live birth	70/1000 live birth
Under-5 Mortality	140/1000 live birth	102/1000 live birth

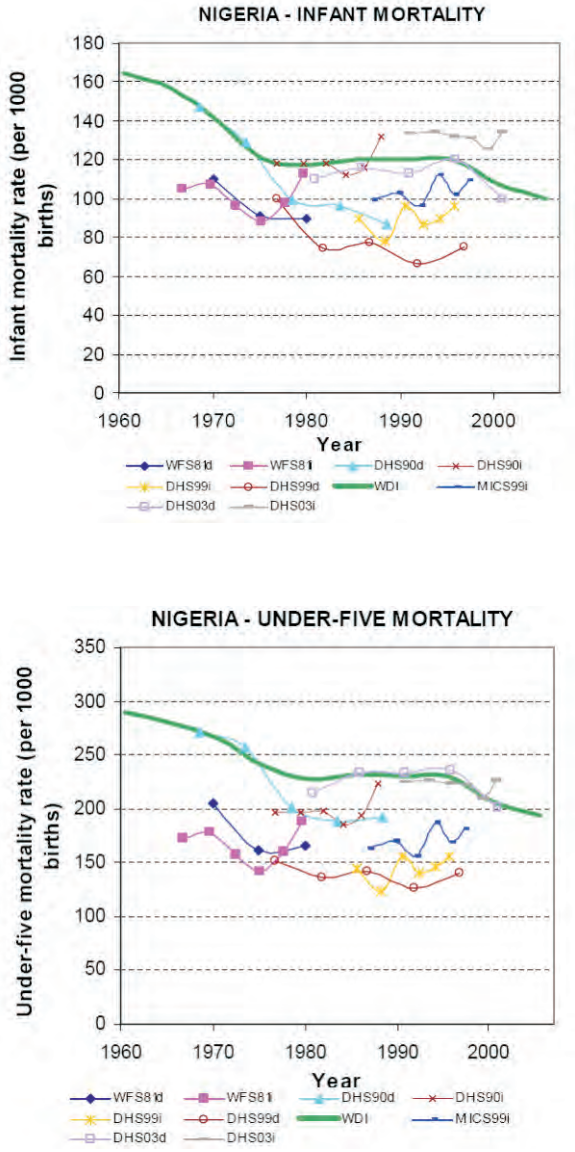


Fig 6. Infant and Under-5 Mortality

Infant & Under-5 Mortalities: Causes and Prevention Strategies

The common causes of Infant & Under-5 Mortalities include Malaria, gastro-intestinal diseases, acute respiratory infections, measles, tuberculosis, and neonatal tetanus. Child survival strategies that have proved useful over the years include preventive measures such as Immunization, oral rehydration therapy, mosquito bed nets, breastfeeding and prevention of mother to child transmission of HIV. National Agencies such as NPI, Primary Health Care (now merged into NHCDA) have existed to coordinate Infant/Childhood Survival Strategies for many years. However, there is no such Agency for maternal survival strategies. In view of the slow progress in the area of maternal health, there is a need for this type of Agency.

RECOMMENDATIONS

- The problem of high maternal mortality is a NATIONAL CRISIS.
- Government should establish a Maternal Mortality Reduction Agency.
- Government should implement existing policies on maternal/infant and child health (MNCH).
- Government should allocate more funds to the health sector.
- Implement free antenatal and postnatal and EmOC care for women, particularly, those that are based in the rural areas.
- Train more skilled attendants at delivery.
- There is need for qualitative education for all health personnel.

Government should redeploy TBAs and use them in community surveillance and mass mobilization to improve access to health care services.