

Maternal health and morbidity beyond 2015: public health and human rights challenges

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TO SAFE ABORTION

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MATTERS

CHALLENGES

- ❖ This presentation is about the public health and human rights challenges related to making pregnancy safe for women.
- ❖ Aim to create a context for the presentations that will follow, which are about improving maternity care – consequences of maternal morbidity, respectful care, and surveillance of maternal deaths to improve services.
- ❖ Pregnancy ends in one of 3 ways – with or without complications and resulting morbidity/mortality:
 - live delivery: premature or at term
 - miscarriage/stillbirth
 - induced abortion
- ❖ The first 2 will be addressed in depth in this meeting but there is very little on abortion. Yet safe abortion care is – or should be – a crucial part of health care for pregnant women.

GLOBAL IMPROVEMENTS

- ❖ The number of maternal deaths has fallen globally in relation to pregnancy over the past century.
- ❖ Work that began in the global North in the early 20th century and became global in the second half of the 20th century can be credited with this. Many of the people in this conference contributed hugely to that.
- ❖ Millennium Development Goals made this work even more of a priority. Many changes began to be visible in the past 15 years.
- ❖ There are important exceptions, however. The least improvement has taken place in sub-Saharan Africa and among the women in socioeconomic quintiles 4 and 5, especially in rural and remote areas, in the poorest countries and in conflict and crisis settings.

MATERNAL DEATH: BRAZIL

COURTESY OF PROF MELANIA M R ANDRIM / DR LEILA KATZ, INSTITUTO DE MEDICINA INTEGRAL PROF. FERNANDO FIGUEIRA



Young woman, 14 years old, primiparous, had repeated seizures (eclampsia) in a rural zone and was transferred, without receiving magnesium sulphate, to the referral hospital, where she died, Recife, Brazil, 2008

MATERNAL DEATH: MOZAMBIQUE



STAFFAN BERGSTRÖM

17-year-old Mozambican girl who died of eclampsia after being brought to hospital in a critical condition

MATERNAL MORBIDITY – NIGERIA

Figure 1. Loops of gangrenous small intestine protruding from the vagina, 20-year-old girl, Lagos University Teaching Hospital, Nigeria.



DATA: MATERNAL MORTALITY

- ❖ An estimated 289,000 women and girls died in 2013 in pregnancy and childbirth.
- ❖ 52% of maternal deaths in 2013 were attributable to haemorrhage, sepsis, and hypertensive disorders. All of these are preventable and treatable.
- ❖ 28% of maternal mortality resulted from non-obstetric causes such as malaria, HIV, diabetes, cardiovascular disease and obesity.
(Global Strategy for Women's and Children's Health, 2016-30)
- ❖ 14.9% of maternal deaths were due to unsafe abortions according to one estimate (Kassebaum Lancet 2014). WHO says 8% based on different methodology and years.

MATERNAL DEATHS: DIFFERENT DATA

- ❖ Globally, the maternal mortality ratio (MMR; number of maternal deaths per 100 000 live births) fell by approximately 44% over the past 25 years; this falls short of the MDG target 5A, which called for a reduction of at least 75%.
- ❖ An estimated 303 000 maternal deaths will occur globally in 2015, yielding an overall MMR of 216 (207–249) maternal deaths per 100 000 live births for the 183 countries and territories with a population higher than 100 000.
- ❖ An estimated 13.6 million women have died in the 25 years between 1990 and 2015 due to maternal causes. Yet the world has made steady progress in reducing maternal mortality.

(Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and UN Population Division, 2015)

DATA: INFANT MORTALITY

- ❖ 2.7 million children who die are newborns: 60–80% are premature and/or small for gestational age.
- ❖ 2.6 million stillbirths in the last 3 months of pregnancy or during childbirth and many millions more miscarriages.

DEATHS IN HUMANITARIAN SETTINGS

- ❖ 60% of maternal deaths, 53% of child deaths, 45% of newborn deaths occur in fragile states and humanitarian settings.

(Global Strategy for Women's and Children's Health, 2016-30)

DATA: ABORTION MORTALITY

- ❖ 44 million women have abortions every year, 21.6 million of them are unsafe, almost all in developing countries. (WHO 2008)
- ❖ The number of deaths from unsafe abortion in 2013 was estimated to be 43,684 = 14.9% of total maternal deaths.
- ❖ The number of abortion-related deaths decreased significantly at the global level and in all regions except Oceania, where no significant change occurred, and in sub-Saharan Africa, where the number of abortion deaths increased significantly. (Kassebaum et al, Lancet 2014)
- ❖ Total abortion deaths in 2008 was 47,000 and the proportion of total maternal deaths = 13%. (Shah & Aahman, RHM 2012)
- ❖ Overall, because maternal deaths from other causes have fallen, deaths from unsafe abortions have increased slightly as a proportion of all maternal deaths, though total number is lower.

ADOLESCENTS

- ❖ Adolescents and young people experience the most unwanted pregnancies, STIs and HIV – they have the most sex and the least access to services. Lack access to sex education.
- ❖ 2.5 million girls under age 16 gave birth in 2012. Evidence is emerging that girls as young as age 10 and 11 are also getting pregnant, often as a result of sexual abuse.
- ❖ In adolescent girls aged 15-19, the two leading causes of death are suicide and complications of pregnancy and childbirth. The two causes are sometimes related.
- ❖ Among women who have unsafe abortions, adolescents suffer the most from complications and have the highest unmet need for contraception – they are still not perceived as eligible for “family planning” in many countries.

DATA: MATERNAL MORBIDITY

- ❖ For every maternal death, which includes deaths from unsafe abortion, there are a larger number of women who survive and suffer complications.
- ❖ There is a long list of obstetric and gynaecological morbidities that women experience.
- ❖ Some are chronic. Some are acute. Some are short-lived & minor.
- ❖ Some are severe and life-threatening, leading to near-misses with long-term sequelae.
- ❖ Quantifying and describing these experiences, because there are so many and so many types of them, is complicated. Hospital record-keeping is not always good and not all women who experience complications are treated in hospitals.

MATERNAL MORBIDITY COMPARED TO MORTALITY

- ❖ The most frequently quoted estimate is that morbidity is 16 times more frequent than mortality, during pregnancy.
- ❖ This is based on a small cohort study conducted in India in 1980. A total of 390 pregnancies, among 290 women, were studied.
- ❖ There were 2 maternal deaths in the cohort (both post-partum haemorrhage) and 33 episodes of illnesses related to the pregnancy recorded.
- ❖ Message: always read the original report. Reviews and quotations are often interpretations not supported by the original data.

(M. Boulvain, Department of Obstetrics and Gynecology, Geneva University Hospital. http://www.gfmer.ch/Endo/Lectures_08/maternal_morbidity.htm)

DATA: COMPLICATIONS OF UNSAFE ABORTION

- ❖ In 26 countries in 2012, an estimated 6.9 million women were treated for complications of unsafe abortion. (Singh et al, 2015)
- ❖ This estimate has increased from 5 million women in 2005 (Singh et al, 2007). Numbers of women of reproductive age have grown a lot since then.
- ❖ The cost to health systems was estimated to be US\$ 232 million each year (Singh et al, 2015) – a heavy burden on scarce hospital resources (up to 50% of hospital maternity beds in some African countries).
- ❖ "Post-abortion care" was proposed at ICPD 1994 as a way to address unsafe abortion without changing the law, but it has failed to resolve the serious public health problem of unsafe abortion.

HUMAN RIGHTS OF PREGNANT WOMEN: CEDAW

- ❖ In 2011, CEDAW introduced a human rights mandate in relation to pregnancy, childbirth and induced abortion re a maternal death case in Brazil (failure to provide care) and denial of abortion after rape in Peru causing permanent disability. (Kismodi, et al, RHM, 2012)
- ❖ CEDAW said that States have a human rights obligation to guarantee that all women – irrespective of their income or racial background – have access to timely, non-discriminatory, and appropriate maternal health services. (→ compensation)
- ❖ They also established that States should guarantee access to abortion when a woman's physical or mental health is in danger, decriminalize abortion when pregnancy results from rape or sexual abuse, review their restrictive interpretation of therapeutic abortion, and establish a mechanism to ensure that reproductive rights are understood and observed in all health care facilities.

STATUS OF WOMEN REFLECTED IN LACK OF CARE

- ❖ Poor quality of maternity care is the cause of morbidity and mortality during pregnancy, delivery and post-partum.
- ❖ Restrictive/criminal laws on abortion and the failure to provide safe abortion services are the cause of abortion-related complications and deaths.
- ❖ The significance of the CEDAW comments were that they identified failure to prioritise making pregnancy safe and guaranteeing services to pregnant women, and failure to make abortion safe and legal as:
 - violations of women's right to life and health
 - a form of discrimination based on class and race, and
 - a form of gender-based violence against women, reflected in and perpetuating their low status.

RESEARCH FOR CHANGE

- ❖ Delays in obtaining care for maternal complications constitute a known determinant of a woman's risk of death. Data on the role of delays in providing care in hospitals are few. The association between the cause of maternal death and the time interval between admission to hospital and the initiation of treatment were evaluated among women who died at the Maternité du Centre Hospitalier de Libreville, Gabon, between January 2005 and December 2007. (Mayi-Tsonga et al, RHM 2009)
- ❖ The mean time between admission and treatment in the case of women who died from post-partum haemorrhage or eclampsia was 1.2 hours (95% CI: 0.0–5.6).
- ❖ In the case of women who died of abortion-related complications it was 23.7 hours (95% CI: 21.1–26.3).
- ❖ Such delays may constitute an important determinant of the risk of death in women with abortion-related complications.

WHAT CAN MAKE THE DIFFERENCE?

- ❖ Understanding the determinants of maternal mortality may be improved by studying cases of severe maternal morbidity for improving treatment.
- ❖ But the occurrence of complications during pregnancy, delivery, post-partum, and during and after unsafe abortions, may depend less on the degree of human development in a country than differences in the way complications are detected and managed.
- ❖ In sum, it is good quality care to begin with, and then quick diagnosis and correct management that contribute to the enormous differences in maternal mortality ratios between countries and regions.

(Cecatti et al, RHM 2007)

**THANK YOU
VERY MUCH!!!**

