Training course in adolescent sexual and reproductive health 2019

Antenatal, intrapartum and postnatal care

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Question 1:

What were the estimated global maternal mortality ratios in 2000 and in 2017?

The third Sustainable Development Goal is to *'ensure healthy lives and promote well-being for all at all ages'.* It targets to end preventable maternal mortality by reducing the global maternal mortality ratio (MMR) by 2030 to 3:1. This means reducing global MMR to less than 70 per 100,000 live births by 2030. The global estimates for the year 2017 indicate that there were 295,000 (UI 279,000 to 340,000) maternal deaths, 35% lower than in 2000 when there were an estimated 451,000 (UI 431,000 to 485,000) maternal deaths. The global MMR in 2017 was estimated at 211 (UI 199 to 243) maternal deaths per 100 000 live births, representing a 38% reduction since 2000, when it was estimated at 342. The average annual rate of reduction (ARR) in global MMR during the 2000–2017 period was 2.9%; this means that, on average, the global MMR declined by 2.9% every year between 2000 and 2017.

Question 2:

What were the global lifetime risks for maternal mortality for a 15-year-old girl in 2000 and in 2017?

The global lifetime risk of maternal mortality for a 15-year-old girl in 2017 was estimated as 1 in 190, which is nearly half of the level of risk in 2000 of 1 in 100. The overall proportion of deaths to women of reproductive age (15–49 years) that are due to maternal causes was estimated at 9.2% (UI 8.7% to 10.6%) in 2017, down by 26.3% since 2000. This means that compared with other causes of death to women of reproductive age, the fraction attributed to maternal causes is decreasing.

Question 3.1:

What was the trend in maternal mortality ratio between 2000 and 2017 in South Asia and how did it compare to the trends in North America during this period?

The global MMR in 2017 for South Asia was estimated at 295 (UI 279 to 340) maternal deaths per 100,000 live births. Between 2000 and 2017, South Asia achieved the greatest overall percentage reduction in MMR of 59% (from 384 to 157). This equated to an average MMR of 5.3%. The global MMR in 2017, for North America, was estimated at 18 (UI 16 to 20) maternal deaths per 100,000 live births. Although North America had a very low MMR of 12 in 2000, its MMR has increased in MMR of almost 52% during this period, rising to 18 in 2017. This is likely related to already low levels of MMR, as well as improvements in data collection, changes in life expectancy and/or change in disparities between subpopulations.

Question 3.2:

What was the trend in maternal mortality ratio between 2000 and 2017 in your country of origin, and how did it compare with the global average?

The global MMR in 2017 for Northern Africa was estimated at 112 (UI 91 to 145) maternal deaths per 100,000 live births. Since 2000, Northern Africa was amongst 5 regions that had roughly halved their MMRs, by 54. The global MMR in 2017 for Egypt was estimated at 37 maternal deaths per 100,000 live births compared to 2000, with 64 maternal deaths per 100,000 live births. This shows a 42% overall MMR decrease from 2000 to 2017. The global MMR in 2017 was estimated at 211 (UI 199 to 243) maternal deaths per 100 000 live births, representing a 38% reduction since 2000, when it was estimated at 342. In contrast, North Africa has a lower estimated MMR of 112, compared to the global MMR of 221 maternal deaths per 100,000 live births. In addition, both Northern Africa (MMR 54%) and Egypt (MMR 42%) achieved a larger MMR reduction, than that achieved by the global MMR of 38%.

Question 4:

Name one recommendation of the report for Primary Health Care systems and for Civil Registration and Vital Statistics systems.

Having targets for mortality reduction is important. Vital statistics generated through civil registration systems are a major source of continuous monitoring of births and deaths over time. Therefore, the usefulness of vital statistics depends on their quality. However accurate measurement of maternal mortality remains challenging and many deaths still go uncounted. There is also, a continued urgent need for maternal health and survival to remain high on the global health development agenda to reduce maternal mortality rates.

Maternal health services require improved accessibility and quality of care, to accelerate reductions in maternal, prenatal, and severe morbidity. The definition of universal health coverage (UHC) must be redefined. Although it is essential to have effective coverage of health services and financial protection (ensuring that no one becomes impoverished because of ill health), it is just as essential that there is a delivery of quality services. Efforts should be made to increase the provision of skilled and competent care to more women, throughout pregnancy, childbirth and postnatal periods. Moreover, there is a complex interplay of experience of mistreatment and lack of support that impact a woman's childbirth experience and outcomes. The WHO have worked towards six strategic areas as a basis for a systematic, evidence-based approach to providing guidance for improving the quality of maternal and newborn care. Of these six strategies, standard of care is prioritized, as there is currently no substantive guidance, although it is the key to ensuring quality of care. Standards explicitly define what is required to achieve high-quality care around the time of childbirth. These can be categorized into eight standards in which need to be assessed, improved and monitored within maternal and newborn care facilities. These eight standards are information systems, referral systems, experience

of care (effective communication, respect and preservation of dignity, and emotional support), an enabled motivated work force and, adequate resources. A rigorous approach was used to identify existing resources, conduct an extensive literature search and map the standards of care of various organizations in order to define and determine their structure. It was proposed that broad standards be set, underpinned by specific quality statements and a number of input, output or process and outcome measures. Eight standards were formulated, one for each of the eight domains of the quality of care framework. To ensure that the standards are specific and focused, 2–13 quality statements were formulated for each standard to drive measurable improvements in the quality of care around childbirth.

Many countries still lack well functioning CRVS systems, and where such systems do exist, reporting errors – whether incompleteness (unregistered deaths, also known as "missing") or misclassification of cause of death – continue to pose a major challenge to data accuracy. Therefore, the Sustainable Development Goals refer to improving CRVS by target 16.9, providing legal identity for all, including birth registration, and target 17.19, the indictor for which is the proportion of countries that have achieved 100 percent birth registration and 80 percent death registration. Civil registration is the only data source from which complete and continuous demographic statistics on population dynamics and causes of death can be generated. The establishment and strengthening of civil registration and vital statistics systems is not simply a by-product of development, but actually contributes directly to development. Therefore, measurements must be driven by action at the country level, with governments creating systems to capture data specific to their information needs; systems that must also meet the standards required for international comparability; and globally, standardized methods for preventing errors in CRVS reporting (i.e. incompleteness and misclassification) should be established to enhance international comparability. Making registration activities subject to the law, and establishing procedural rules and regulations, is essential for the efficient management, operation and maintenance of CRVS systems. Legislation helps to ensure the completeness of registration and to improve the accuracy of information held in the civil record. Obligatory registration, deadlines and penalties for non-compliance cannot be enforced without relevant laws in place. Laws are also needed to safeguard the personal information of individuals by ensuring that it remains confidential and secure, and protecting against its misuse. Finally, anchoring civil registration in a law helps to ensure the continuity, consistency, correctness and comprehensiveness of CRVS systems.

Question 5.1:

Identity the 1st, 2nd, 3rd order themes within the typology of mistreatment of women experienced during childbirth in the following case study.

The WHO conducted a mixed-methods systematic review to develop a typology of what constitutes mistreatment of women during childbirth. These were categorized into 1st order themes that identify criteria describing specific events or instances of

mistreatment. The 2nd and 3rd order themes further classify these 1st order themes into meaningful groups based and common attributes. The 3rd order themes are ordered from the level of interpersonal relations through the level of the health system and divided into seven; physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, health system conditions and constraints. In this specific case, five of seven 3rd theme typology of mistreatment of women experienced during childbirth can be identified; verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints.

'Verbal abuse' as a 2nd order theme constitutes as 'harsh language' and 'threats and blaming'. 'Harsh language' as a 1st order theme is 'judgmental or accusatory comments' - *While making love, you were not crying there, and here during childbirth you cry'*. Many women experiencing childbirth report feeling ashamed by health workers, who made inappropriate comments to them regarding their sexual activity. This is an intentionally lewd comment, to which is used to humiliate the women while she is already in a vulnerable position during childbirth and in need of supportive care. A correlation can be identified between 'verbal abuse' and the 3rd order theme of 'stigma and discrimination', 2nd order theme of 'discrimination based on socio-demographic characteristics' and 1st order theme of 'discrimination based on age' – *'After giving birth for the first time, a 20 year old'.* Adolescent or unmarried women may experience insensitive comments more frequently since many communities view pregnancy and childbirth as appropriate only in the context of marital relationships. Women are often ridiculed for engaging in sexual activity before marriage. The next incident of the 3rd order theme of 'verbal abuse' is 'threats and blaming' as a 2nd order theme, and 'threats of withholding' as a 1st order theme. This is apparent when the health worker threatened the woman when she did not comply with her demands and withheld health services – *'The midwife told her that if she did not get on the table and lie down, she would leave. And she did for a few minutes'.* This can also constitute as a 3rd order theme of 'failure to meet professional standards', 2nd order theme of 'neglect and abandonment' and 1st order theme of 'neglect and abandonment'– *'the woman said that she was abandoned during child birth'.* Women often report feeling alone, ignored and abandoned during their stay at the facility, and felt that their request for help or attention from health workers was an imposition. This neglect may directly increase the physical risk women face during delivery.

'Poor rapport between women and providers' as a 2nd order theme constitutes as 'ineffective communication', 'lack of supportive care' and 'loss of autonomy' - *She said that she couldn't at that moment because the baby was between her legs. The midwife told her that if she did not get on the table and lie down, she would leave'.* There is an inter-link between these themes. 'Ineffective communication', as a 1st order theme is 'dismissal of woman's concerns' and 'poor staff attitude'. Some

women refer to providers as having negative attitudes, unsupportive, unhelpful, rude, impolite, unprofessional, or unkind. The health worker was more interested in having the woman comply with her demands than in allowing the woman to express her concerns. 'Lack of supportive care', as a 1st order theme is 'lack of supportive care from health worker'. Women commonly reported a lack of supportive care during childbirth in facilities, including the perception that the care provided by health workers was mechanical and lacked comfort and courtesy. During their deliveries, women often felt that they did not receive the time and attention from health workers to make them feel supported and adequately cared for. Women felt that health workers were insensitive to their needs. They also felt that they were provided with systemized, mechanistic care that focused solely on technical outcomes rather than supportive care that incorporated sensitive communication and a comforting touch. 'Loss of autonomy', as a 1st order theme is 'women treated as passive participants' and 'lack of respect for woman's preferred position'. Some women preferred to deliver in positions other than the supine position, such as by squatting or kneeling, and resented that health workers forced them to deliver in undesirable positions. Women felt that adopting an undesirable birth position at the demand of the health worker made them passive participants in their childbirth process.

The 3rd order theme of 'health system conditions and constraints' contributes to the mistreatment and abusive environment of women during childbirth they experience. In this case, it can be considered a 2nd order theme of 'lack of resources' and 1st order theme of 'staffing shortage'. Staffing shortages not only contributed to neglectful or poor-quality care but also health workers' negative attitudes. Health workers discussed how the hierarchical authority in the health system legitimized the control that health workers have over their patients and contributed to the detrimental treatment of women during childbirth. These power differentials place women at the bottom of the hierarchy, where their needs and concerns were often ignored or deemed as unimportant by health workers. Furthermore, the lack of supportive supervision for health workers from their superiors contributed to feelings of demoralization and negative attitudes, thus perpetuating the mistreatment of women. As a result of past negative experiences, both health workers and patients may have come to expect and accept the poor treatment of women as the norm.

Question 5.2:

Name the WHO document which addresses respectful care during childbirth.

The WHO document which addresses respectful care during childbirth is *'Intrapartum Care for a Positive Childbirth Experience'* (WHO, 2018). It advocates for individualized and woman-centered labor and childbirth through respectful labor and childbirth care, effective communication by staff and emotional support from a companion of choice. These are in line with the WHO quality of care vision and framework. Its clear objective is that childbirth should be a positive experience for the

woman, the newborn, and her family. This recommendation can be further complemented by *'Prevention and elimination of disrespect and abuse during childbirth'* (WHO, 2014).