

From Safe Motherhood to Sustainable Development Goals: Unmet Targets; What are We Missing?

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ABSTRACT

Maternal mortality (MM) has been an important issue for years, but it is only within the last 50 to 100 years that the global health community has started focusing its attention on it. In an attempt to reduce MM, programs were formulated and implemented. Such programs include the safe motherhood initiative (SMI) of the 80s, the millennium development goals (MDGs: 2000 to 2015), and currently the sustainable development goals (SDGs). The SMI attempted to reduce MM but failed to do so as envisaged and to improve on it, the MDGs were implemented. Although the MDGs made significant inroads in reducing MM, like its predecessor, it failed to achieve 100% success. As we are on the verge of starting another attempt (SDGs), we must identify the impediments that limited the success of the two previous programs. We need to inject new innovations into the SDGs to make them a success. Emphasis should now be on information, access, and quality of care provided during the intrapartum and postpartum periods which are the times when most MM occur. New ideas such as setting up maternity clusters should be implemented for the hard-to-reach communities. This approach can be the panacea to reduce MM especially in the developing countries.

Keywords: Millennium development goals, Safe motherhood initiative, Sustainable development goals, Unmet targets.

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INTRODUCTION

Maternal health has been an important issue for years and will remain so for as long as maternal mortality (MM) remains at the current unacceptable high rate. In 1930, the league of Nations Health Section noted concerns about MM.¹ Attention to the health of mothers and children is an explicit element of World Health Organization constitution and efforts to promote maternal and child health and welfare are included among the functions of the organization.¹ Since the 1980s, global discussion on health has been focused on MM. International Federation of Gynaecology and Obstetrics (FIGO) in 1982 established a task force to draw attention to safe motherhood initiative (SMI) at the global and regional levels and in 1997 established the SMI Fund.¹ In 1987, the Safe Motherhood Conference was held in Nairobi, Kenya, with the objective of reducing MM by 50%, among other things.² All these are in recognition of the pivotal importance of the health of mothers and children in the sustenance of the human race.

The MM rate in the USA in 1900 was 700/100,000¹ and is similar to the current rates in most developing countries. After 100 years, the MM rate in the USA had fallen to less than 10/100,000.¹ Similar precipitous declines occurred in other industrialized countries over the same period.¹ This is achieved with advent of technologies and drugs to prevent and manage obstetric complications.³ The causes of MM in the developed nations are the same as those in the developing ones. The leading causes of MM in the developing countries are hemorrhage, sepsis, and hypertensive disorders of pregnancy. These are the same leading causes of MM in the USA.^{4,5} Maternal mortality due to complications of abortions and obstructed labor are still seen in developing countries but are hardly seen today in the developed countries. The knowledge and the means to achieve success are also available in the developing countries. The question is why are we still grappling with the menace of MM?

The need to achieve a significant drop in MM rate universally was the motive behind the establishment of various programs and policies over the years. These programs include the SMI, millennium development goals (MDGs), and currently the sustainable

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development goals (SDGs). The question is have we achieved the desired goal of lowering the MM rate globally? If not, what are the impediments preventing the achievement of this objective?

UNMET TARGETS

The SMI of 1987 was designed to achieve a 50% decline in MM by the year 2000.² A total of 189 countries committed themselves to make this a reality. Although SMI was implemented for more than a decade, MM was not reduced to the extent that was envisaged. Was it because of lack of resources, lack of focus, lack of political will, or a combination of all these?

Scarcity of resources is an issue in many developing countries but is it the main issue? The answer is no for the following reasons: (1) resources are misapplied in many developing countries to projects that do not impact positively on the lives of the people. (2) Resources are depleted by endemic corrupt practices. (3) The developing world today gets a lot of resources from donor agencies. (4) A shining example of a resource-limited country that has significantly reduced its MM is Sri Lanka. In 1990, the MM rate

in Sri Lanka was 75/100,000 and in 2015 it is 30/100,000.⁶ What is needed to achieve success, therefore, is curbing corruption, appropriate channeling of resources to where they are needed the most, and coordination and harmonization of resources and programs to be in line with the national objectives set to address MM. Even where resources are abundant, absence of political will be a great impediment to reducing MM. Sri Lanka has been relentless in implementing a comprehensive maternal and child health (MCH) program from the 1950s to date even in the face of a protracted civil war. This is a classic example of the impact of political will in achieving success in a nation that is very determined.

The SMI has a wide focus and it contains some elements, which though very important however require long gestation period to manifest their efficacy and effectiveness in reducing MM. Antenatal care (ANC) is now widely accepted by pregnant women and many attend at least once during their pregnancy period. Lots of resources are allocated to it. Predicting risks is one of the tasks of ANC, but risk prediction is an outdated model used in preventing MM. The vast majority of high-risk women will deliver without incident. On the contrary, women who develop life-threatening obstetric complications belong to the low-risk groups.³ In all, 11 to 17% of MM occur during the intrapartum period and 50 to 71% occur postpartum.⁷ The intrapartum period is thus critical in preventing MM and yet intrapartum care provided by trained birth attendant is lacking in most developing countries. Any intrapartum mishap will lead to catastrophic outcome for both mother and baby, including death. If the SMI had emphasized on intrapartum care by providing quality basic/comprehensive emergency obstetric care, the success recorded would have been much more. The postpartum period is also very critical to the survival and well-being of mothers, but in developing countries this aspect of care is virtually absent. With the implementation of well-organized postpartum care, we would have recorded a geometrical decline in MM. An important area that was addressed by the SMI is family planning and child spacing, again though important and can potentially reduce MM by preventing unplanned and unwanted pregnancies,³ it is resource intensive and will take a longtime for it to be entrenched and have a positive impact on MM. Although the MDGs showed improvement especially in those places where the SMI has failed, the MDG targets were not met 100%. The SDG 3 includes an ambitious target "reducing the global MMR to less than 70/100,000 births, with no country having MM rate of more than twice the global average" by 2030.⁸ So for the SDGs to succeed in reducing MM in the developing countries, new ideas and innovations need to be injected into it taking lessons from what has impeded the full realization of the SMI and the MDGs. A paradigm shift is necessary for this to be realized.

Developing countries have peculiar sociodemographic, political, and economic circumstances that are much different from those in the developed countries. These sometimes hinder the success of policies and programs that were used successfully in developed countries.

WHAT ARE WE MISSING?

The panacea to success requires us to discard the dogmas and adopt the trio. The dogmas are risk assessment in ANC leading to decline in MM, the belief that prevention is better than cure, and the centralization of maternal healthcare services in urban areas which are far away from the bulk of those in need. Antenatal care is a good and an indispensable form of care for the pregnant woman but in itself ANC cannot reduce MM without a

good and efficient intrapartum and postpartum care. A woman may receive quality ANC, but at the point of delivery if she has no access to quality intrapartum care, she may suffer from severe obstetrical complications and die. If she receives good ANC and intrapartum but had no access to quality postpartum care, obstetrical complication may take the toll on her and she may die. The issue of using ANC to predict risk and thus prevent MM is a dogma that must be discarded because it has been shown that many of those identified as being at risk go through pregnancy without sustaining complications, while those identified as being at low risk suffer serious obstetrical complications. Fortunately, however, the importance of emergency obstetric care in preventing maternal deaths has gradually been accepted by most international agencies.⁹⁻¹¹ If we look at the locations of hospital that provide secondary and tertiary care services in most developing countries, we can easily see that there is preponderance of these hospitals in the urban areas. Resources and personnel are concentrated in these urban hospitals. The rural areas where the bulk of the population lives are left with a few resource-deprived and understaffed primary healthcare centers. This policy has to be taken into consideration and must be reversed to ensure the success of the SDGs.

For a successful implementation of the SDGs, we have to accept the trio as tools (information, access, and quality). Information is power and it has to be provided through various media. The radio is such an important tool because it is used by most people in the rural areas of the developing world. Through this medium, vital information on various maternal and child health issues can reach the people. Information on the need to prepare when a woman is pregnant, the various danger signals (bleeding, drainage of amniotic, symptoms/signs of preeclampsia, etc.) in pregnancy, where to seek care at the time of need, and how to reach the sites can all be disseminated via the radio. It can also be used as a medium for community mobilization to achieve better health outcomes. Access to care is crucial in reducing MM. Everything may be available but if they are inaccessible to those in need, then all are lost. Women should be able to access hospital within a reasonable time in case of need. Means of transport is an important element in accessing point of care. Locating health facilities within reasonable distance to the target communities is important because time is of essence during emergencies. Spread of facilities providing maternal care makes access much easier. Primary healthcare facilities should have the capacity to give basic obstetric care at all times. Quality is the ultimate measure that determines life or death in cases of obstetrical emergencies. Quality is measured in terms of the availability of adequate number of well-trained and adequately motivated personnel manning the facilities. The equipment at the disposal of those working at the hospitals determine what they can and what they cannot do. These together with the availability of daily consumables at any given point in time also matter in terms of saving lives and preventing complications and death. Service provision should be 24/7 and this can only be possible when the personnel are provided with decent accommodation within or close to the facility where they work. Again as part of quality, there is a need for an efficient and effective referral system linking primary facilities to secondary/tertiary facilities.

There is a need to accept new innovative approaches and one such approach is establishing "maternity clusters". These are facilities where the hard to reach can be accommodated close to the time of delivery and located close to hospitals. This is important because some communities live in areas with very difficult terrain and people in such areas may not be able reach a facility at times of emergency.

CONCLUSION

Maternal mortality has been a very difficult problem to prevent especially in the developing countries. Although the causes are known and the treatment is available, achieving a reasonable reduction has been such a daunting task in the developing countries. Various programs and policies have been used over the years but yet the problem persists. Lessons learned from previous programs as to why success has eluded us should be used to devise new strategies to ensure success for the current SDGs. We should be open to new approaches and ideas as we implement the SDGs. Information, access, and quality are panacea to the reduction of MM in the long run.

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