Maternal Mortality In Africa

D Abdoulaye

Citation

D Abdoulaye. *Maternal Mortality In Africa*. The Internet Journal of Health. 2005 Volume 5 Number 1.

Abstract

The rise in Maternal Mortality Ratio (MMR) is mostly affecting developing countries. 47% of global Maternal Mortality (MM) occurred in Africa, with the highest rate in Sub-Saharan countries. It is a great calamity because 85% of all maternal deaths are direct results of complications arising during pregnancy, delivery or the puerperium. Home deliveries are over 60%, largely in rural areas without skilled attendant. Many organisations try to fight the plague: West African Health Organisation (WAHO), World Health Organisation (WHO), United Nations Population Fund (UNFPA), USAID/AWARE-RH/WARP, Prevention of Maternal Mortality Network (PMMN), Confidential Enquiry into Maternal and Child Health CEMACH .

Statement of Maternal Mortality: The chance of woman dying from complication of pregnancy, delivery or the puerperium is stated in the world, as followed: Africa: 1/15, Asia: 1/105, Europe: 1/1895, North America: 1/3750
It is easy to notice two opposite statements:
First statement- MM in Developed Countries is brought to a very low rate, because of a hard political will, an appropriate implementation of programs (prevention and treatment)
Second statement- MM in Developing Countries, especially in Africa, is alarming, marked by a rate 100-200 times higher than the one of developed countries. This drama is related mainly to socio-economic conditions (poverty and unequal repartition of wealth) and the 3 delays to provide adequate obstetrical cares: acceptability, accessibility, availability. Various studies in Benin, Burkina Faso, Congo, Ivory Coast, Madagascar, Mali and Uganda, agrees that the causes of the calamity in Africa are dominated by Haemorrhage (30%), Sepsis (18%), Eclampsia (13%), and Abortion (10%).

Six Strategies are identified for reducing Maternal Mortality:
Increase of the socioeconomic level of population, Improvement of Family Planning Services, Development of Emergency Obstetrics Care (control of the 3 delays), Strengthening of Adolescent Health, Control of abortion, Increase collaboration between specialised networks.

Specific actions bound to strategies, can be mixed to fight Maternal Mortality in Africa through: Advocacy, Social Mobilisation, Capacity Building, Partnership development, Dissemination of best practices/approaches and Monitoring & Evaluation. These actions can be supported by a strong Implication of Stakeholders: Government, Community, Private Sector, Partners

Conclusion: Maternal mortality in Africa continues to be a serious public health problem. Any success in this domain requires an adequate political will, appropriate multidisciplinary programmes of prevention and early management of cases in obstetrical resuscitation units.

INTRODUCTION

The rise in Maternal Mortality Ratio (MMR) is mostly affecting the developing countries. 47% of global Maternal Mortality (MM) occurred in Africa, with the highest rate in Sub-Saharan countries ([1], [5]). It is a great calamity and because 85% of all maternal deaths are direct results of complications arising during pregnancy, delivery or the puerperium. Home deliveries are over 60%, largely in rural areas without skilled attendant ([6],[7],[8],[9],[10]).

Many organisations try to fight the plague, among which we can mention:

- WAHO - West African Health Organisation
- WHO – World Health Organisation
- PMMN - Prevention of Maternal Mortality Network
- UNFPA – United Nations Population Fund

- USAID/AWARE-RH/WARP
- CEMACH -Confidential Enquiry into Maternal and Child Health (Ex CEMD & CESDI) under the umbrella of the NICE - National Institute of Clinical Excellence, Etc...

STATEMENT OF MATERNAL MORTALITY

The chance of woman dying from complication of pregnancy, delivery or the puerperium is various in the world different areas, as followed:

- Africa 1/15
- Asia 1/105
- Europe 1/1895
- North America 1/3750
    - It is easy to notice 2 opposite statements in the world:
- MM in Developed Countries, brought to a very low rate, because of a hard political will, an appropriate implementation of programs (prevention and treatment);
- MM in Developing Countries, especially in Africa, alarming, marked by a rate 100-200 times higher than the one of developed countries. This drama is related mainly to socio-economic conditions (poverty or unequal repartition of wealth) and the 3 delays to provide adequate obstetrical cares: acceptability, accessibility, availability (3,4).

Various studies ([1,2,3,4, 7,8,9,10]) in Benin, Burkina Faso, Congo, Ivory Coast, Madagascar, Mali and Uganda agree that the causes of the calamity in Africa are dominated by:

- Haemorrhage (30%)
- Sepsis (18%)
- Eclampsia (13%)
- Abortion (10%), occurred in adolescents

STRATEGIES FOR REDUCING MATERNAL MORTALITY

Six strategies are identified to struggle efficiently the plague ([2, 3, 7, 8]):

- Increase of the socioeconomic level of population
- Improvement Family Planning Services
- Development of Emergency Obstetrics Care (trough the 3 delays)
- Strengthening of Adolescent Health
- Control of abortion
- Increase collaboration between networks specialised in Maternal Mortality

SPECIFIC ACTIONS BOUND TO STRATEGIES

Specific actions can be mixed to fight this fearsome curse, through ([6]):

- Advocacy
- Social Mobilisation
- Capacity Building
- Partnership Development
- Dissemination of best practices/approaches

ADVOCACY

- Adequate Legislation
    - Encourage education of women and girls
    - Review abortion laws
    - Forbid early marriage
    - Outlaw Female Genital Mutilation, Excision
- Resource Mobilisation for Networks like PMMN (Prevention of Maternal Mortality Network)
- Multi Sectoral Approach
- Ensure National Policies that promote Maternal Health (MH) especially Family planning
- Establishment of Centres to provide information and education for adolescents
- Promotion of good quality Family Planning Services

SOCIAL MOBILISATION

- Develop Mutual Cooperatives for
    - Health Cost sharing
    - Transportation for pregnant women
    - Free access to all emergency care particularly Obstetrics Care
    - Promote health facility management committees
- Male Involvement information, motivation by BCC
- Women Empowerment, Women Promotion

CAPACITY BUILDING

- Development of training and retraining of Obstetricians, Anaesthetics, Midwifes, Matrons and Traditional Birth Attendant (TBA)
- Updating standards Settings
- Ensure Training in Management for health providers

PARTNERSHIP

- Strength of Partnership: by Memoranda of Understanding (MOU), Annual Reviews, Workshops Networking and Information Sharing
- Monitoring and Evaluation and Resource Mobilisation

DISSEMINATION OF BEST PRACTICES/APPROACHES

- Use of best practices and approaches in Maternal Health (Identification and Evaluation)
- Dissemination of practices and approaches through Newsletters, study focus, professional journals, website, e-list
- Promotion of Research in best practices like the instauration of an annual grant for research

It is clear for us, that the management of major obstetric matters remains a challenge and requires close teamwork, in which anaesthetists can play a major part.

MONITORING & EVALUATION

By regular check of indicators, in the beginning, the mi-term and the end of each programme.

IMPLICATION OF STAKEHOLDERS

- Government,
- Community
- Private Sectors
- Partners: like AFRICAN UNION, WHO, ECOWAS PARLIAMENT, UNICEF, USAID/AWARE-RH/WARP , WOMENS ORGANISATIONS, UNFPA, PMMN, CS, EU, CF, CIDA, WB, ADVANCE AFRICA

CONCLUSION

Maternal mortality in Africa continues to be a serious public health problem. Any success in this domain requires an adequate political will, appropriate multidisciplinary programmes of prevention and early management of cases in obstetrical resuscitation units.

References

1. Bouhoussou Mk, Houphouet Kb, Djahan Y, Sangaret Ma Ruptures Utérines Au Cours Du Travail A Propos De 128 Cas.Afr. Méd,1978 ; 17, 162 :467 -472.
2. Chobli M., Tovone G., Lokossou T, Afan A , Takpara I., K. Mignagnal Maternal Mortality: View From The Developing World 13th World Anesthesia Congress. Paris 2004
3. Deborah M., Murat Z. A , Victoria M.W , Angela K. La Conception Et L'évaluation Des Programmes De Prévention De La Mortalité Maternelle Centre De Santé Des Populations Et De La Famille. Ecole De Santé Publique. Université De Columbia. New York, 1997
4. Takrouri Msm, Seraj M. A., Baaj J., Al Jasser M., Al Satli R, Turkustani R., Gourab S., Al-Jabari A, Al-Meshari A.A.: Intensive Care Management For Patients With The Syndrome Of Hemolysis Elevated Liver Enzymes And Low Platelets (Hellp Syndrome). The Internet Journal Of Emergency And Intensive Care Medicine. 2004. Volume 7 Number 2.
5. Mohana N: Maternal Mortality In Islamic And Arabic Countries. The Internet Journal Of Health. 2005. Volume 4 Number 1.
6. Diallo A, Maïga B, Dolo A, Traoré J, Kané M, Touré Mk, Mounkoro N, Samaké S La Mortalité Maternelle Au Mali 45ième Congrès De La Société Française D'anesthésie-Réanimation. Sfar .Club D'anesthésie - Réanimation D'afrique Francophone, Caraf. Paris, Septembre 2003
7. Diallo A. , Doumbia D., Sahare F., Traore Jeanette T., Maïga I., Coulibaly Y., Alexis R., Toure M, Kone A., Traore A.K., Toure K. M. Hellp Syndrome In Mali The Internet Journal Of Gynecology And Obstetrics. 2005. Volume 4 Number 1.
8. Kabba T. Joiner West African Health Organisation Stratégic Plan For The Reducing Of Maternal And Perinatal

Mortality In West Africa. Assembly Of Ecowas Health Ministers. Accra 28-29th Oct 2004
9. Sanou J. , Lankoande J, Traore Ss, Akotionga M, Ouedrago Rmc, Kone B Les Césariennes En Extrême Urgence Au Centre Hospitalier National De Ouagadougou Mali Médical 1999 ; T Xiv, No 3et 4
10. Shasha W., Binam F. , Afane Ela A., Foncha C., Bayiha J., Fomulu N., Doh A.Evaluation Du Circuit De Transfert Secondaire Des Urgences Obstétricales Et Mortalité Foeto-Maternelle A Yaoundé. Rev. Afr. Anesth. Méd. Urg.,3 :19-26,1996

Author Information

Diallo Abdoulaye
Chief, Department of Emergencies, Anaesthesia & Intensive Care, Point G Hospital, University of Bamako