Maternal mortality: Lessons of the millennium development goals, a way forward

Ntiense M Utuk, Aniekan M Abasiattai

The death of a female patient during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, due to any cause related to or aggravated by the occurrence pregnancy or its management, but not from accidental or incidental causes is called maternal mortality [1]. The latest estimated maternal mortality ratio in Nigeria is 576/100,000 live births [2] which is certainly an underestimation. Vital statistics in a low resource setting such as Nigeria are often incomplete or do not exist and estimates are often based on hospital data which may not reflect the maternal risk within communities. In comparison, the maternal mortality ratio in Denmark is 5.3/100,000 live births. The commonest causes of maternal mortality include haemorrhage, unsafe abortions, hypertension in pregnancy, infections and obstructed labor [3]. These are all direct causes of mortality but a variety of other factors contribute to the delay in a pregnant women seeking help in the presence of complications.

A three-delay model was presented for the understanding of the factors which could contribute to maternal mortality [4]. These were delay 1- the decision to access care, delay 2- the transport to a medical facility, and delay 3- the receipt of adequate treatment. These factors are interrelated. For example, socioeconomic, cultural factors, religion, financial and educational factors may lead to a delay in taking a decision to access care. On the other hand, institutional factors and lack of personnel, material may reinforce negative stereotypes about care provided in hospitals and lead to a reluctance to access care. Thus, maternal mortality is seen to be due to a different factors, and not only depends upon the economic or human factors.

There have been various initiatives in Nigeria to reduce the high maternal mortality ratio. The various methods include include the adoption of the safe motherhood program which was launched in Nairobi 1987; the roadmap for acceleration of the attainment of the millennium development goal 4 and 5 in 2005; and the integrated maternal, child and newborn health strategy of 2007 [5]. However, pregnant women continue to die in large numbers from preventable conditions associated with pregnancy.

The recent adoption of the WHO Sustainable Development Goals (SDG) seeks to leverage the momentum generated by the MDGs. It seeks to reduce the maternal mortality ratio to 70/100,000 live births by the year 2030 [6]. However, lessons must be learnt from the failure of the MDGs if the SDGs are to have any hope of achievement.

Various factors have been found to be responsible for the failure of the MDGs. These include lack of human capacity for implementation, poor access to health care delivery systems with its high cost, unreliable data systems, inadequate funding and endemic corruption [7]. Other factors also include sequential industrial actions by health care workers, poor coverage of the National Health Insurance Scheme so that 60% of health care expenditure are out-of-pocket expenses, and the Boko Haram insurgency in the north of the country [8]. These factors can be conceptualized within the 3-delay model of maternal care.

The 3-delay model also helps explain why Nigerian women die during pregnancy. In Nigeria it is known that only a third of deliveries occur in the presence of a skilled attendant [2]. Most pregnant women deliver in unorthodox health care facilities even though it has been shown that the outcome in such places is poor [9]. A variety of reasons are given for the reluctance to access orthodox care. These include fear of spiritual attacks, fear of caesarean section and episiotomy as well as the high cost of orthodox health care [10]. These are some of the factors responsible for level 1 delay. Atser and Akpan [11] in 2009 also demonstrated the inequity in the spatial distribution of health care facilities in Akwa-Ibom state in Nigeria. Of the 31 local governments studied,
status of the population by creating job opportunities should be a general improvement in the socioeconomic have to be multifacet and all encompassing. Firstly, there done to achieve the sustainable development goals.

skilled attendant 38% [2]. Clearly, work still needs to be coverage (4 visits) was 51.1%, and births attended by a contraceptive prevalence rate was 15.1%, antenatal care demographic figures, the fertility rate per woman was 5.5, was $1669. According to the latest national health and figures on these indices make for grim reading in Nigeria. The average per capita income between 1981 and 2017/100,000 live births is associated with a per capita income of $2648, a total fertility rate of 2.0, and completing 12 years of education [6]. Further, to achieve the same aim, they also required: 78% of pregnant women should have a skilled attendant at birth of deliveries should be in-facility deliveries, and 87% of women should attend at least four antenatal visits, 81% of the number of children per couple. This must include comprehensive sex education, multiple methods of modern contraception and access to safe abortion. In this regard, restrictive abortion laws currently in place in Nigeria should be liberalized. Hospital practices should be reviewed to encourage attendance. This includes free and accessible antenatal services which offer high quality care; adequate staff and material to cater to in-facility deliveries and skilled birth attendant services; and provision of emergency obstetric services. These measures, if instituted, will help make the sustainable development goals attainable in 2030.

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Author Contributions
Ntiense M Utuk – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Interpretation of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

Aniekan M Abasiattai – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Interpretation of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

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