Reduction of Maternal mortality-South Asian initiative: a round table conference at the India international centre, Delhi on 8th September,

"One pregnant woman dies every minute ……"

Report on Round Table Consultation

Delhi, 8th September, 2010

Global India Foundation

In Partnership with:

Royal College of Obstetricians and Gynaecologists

Liverpool School of Tropical Medicine

Rotary International

Federation of Obstetric and Gyaecological Societies of India

National Institute of Health and Family Welfare, Government of India

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I. Why Mothers Die?

1.1 Globally, more than half a million women die each year because of complications related to pregnancy and childbirth. Of the estimated 536,000 maternal deaths worldwide in 2005, developing countries accounted for more than 99 per cent. About half of the maternal deaths (265,000) occurred in sub-Saharan Africa alone and one third took place in South Asia (187,000).Thus, sub-Saharan Africa and South Asia accounted for 84 per cent of global maternal deaths, with hemorrhage the leading cause of death in these regions. Sepsis, prolonged or obstructed labor, the hypertensive disorders of pregnancy, especially eclampsia, and complications of unsafe abortion, claim further lives.

Hemorrhage is the leading cause of maternal death in Africa and Asia
Causes of maternal death (1997–2002)

1.2 These complications can occur without warning at any time during pregnancy and childbirth. And for every woman who dies, approximately 20 more suffer injuries, infection and disabilities. Complications require prompt access to quality obstetric services equipped to provide lifesaving drugs, antibiotics and transfusions and to perform Caesarean sections and other surgical interventions.

1.3 The foundations for maternal mortality risk are often laid in girlhood. Women, whose growth has been stunted by chronic malnutrition or vitamin deficiencies, are vulnerable to obstructed labour. Anaemia predisposes to hemorrhage and sepsis during delivery and has been implicated in at least 20 per cent of post-partum maternal deaths in Africa and Asia. The risk of childbirth is even greater for women who have undergone female genital mutilation, an estimated 2 million girls every year.

1.4 The factors that cause maternal morbidity and death also affect the survival chances of the fetus and newborn, leading to an estimated 8 million infant deaths a year (over half of them fetal deaths) occurring just before or during delivery or in the first week of life.

2. The global burden of maternal mortality

2.1 The maternal mortality ratio (MMR) is defined as the number of maternal deaths per 100,000 live births. Sub-Saharan Africa suffers from the highest MMR at 920 maternal deaths per 100,000 live births, followed by South Asia, with an MMR of 500. This compares with an MMR of 8 -10 in industrialized countries.

Maternal mortality is highest in countries of sub-Saharan Africa and South Asia
Maternal mortality ratios (MMR) per 100,000 live births (2005)

3. Lifetime Risk

Lifetime risk is the probability that a woman will die from complications of pregnancy and childbirth over her lifetime; it takes into account both the maternal mortality ratio (probability of maternal death per childbirth) and the total fertility rate (probable number of births per woman during her reproductive years). Thus in a high-fertility setting a woman faces the risk of maternal death multiple times, and her lifetime risk of death will be higher than in a low-fertility setting. The lifetime risk of maternal death in the developing world as a whole is 1 in 76 compared with 1 in 8,000 in the industrialized world. This gap becomes a yawning chasm if the countries with the best and worst records are compared: In Ireland, women have a 1 in 47,600 lifetime risk of dying during pregnancy or from a birth-related cause, whereas women in Niger face a 1 in 7 lifetime risk.

4. Progress towards MDG 5

Millennium Development Goal Target 5A calls for a reduction in the maternal mortality ratio by three-quarters between 1990 and 2015. At the present rate of progress, the world will fall well short of the target for maternal mortality reduction. The data suggest that to reach the target, the global MMR would have had to be reduced by an average 5.5 per cent a year between 1990 and 2015. The current average rate of reduction is less than 1 per cent a year. The estimated 0.1 per cent annual rate of reduction in sub-Saharan Africa, where levels of mortality are highest, is slower than in any other region.

Varied progress in maternal mortality across regions
Trends in the maternal mortality ratio, by region (1990 and 2005)

5. International Parliamentarians Report

5.1 Parliamentarians from African, Asian, European and G8 countries gathered in Rome, Italy **in June 2009** to highlight progress or lack of it in Maternal Mortality Reduction Strategies. They noted that the international commitment to improve maternal health (MDG 5) and to reduce child mortality (MDG 4) by 2015 are the Millennium Development Goals most off track and progress to achieve these goals has been stalled,.

5.2 The Parliamentarians highlighted a number of strategies for effective and achievable reduction of MMR. These include appeal to the G 8 Governments to

1. Reinforce existing Health Commitments: to fund US$ 60 Billion through Official Development assistance (ODA)
2. Invest in Maternal Health and recognise the need for advocacy and finance behind a commonly agreed set of policies and interventions
3. Explore and Use innovative Financing Mechanisms
4. Respect Women's and Girl's Right to Health as a Human Right
5. Drive the future Maternal and Newborn Health Agenda

6. South East Asia Situation

6.1 Within the South Asian region, there are wide variations in the rate. Examples include Sri Lanka (25) ,India as a whole (254) Assam (480),Tamil Nadu (54),Bangladesh (430) and Nepal (430). Nepal itself has shown a big drop between 2001 and 2008. ***

6.2 The differences can be due to variations in poverty levels, literacy, social factors such as childhood marriage, differences in medical care including antenatal care, proportion of deliveries in Institutions or under care of Skilled Birth Attendants, lack of equipment and drugs at the place of delivery, lack of transport, policy issues, incomplete or inadequate reporting strategies and other factors.

6.3. The two most effective parameters reducing maternal mortality are high incidence of institutional delivery and high incidence of antenatal care and delivery by skilled birth attendants. Accountability and transfer of responsibility are also important.

7. National Round Table Consultation held by Global India Foundation in New Delhi -September 2010

7.1 Under the auspices of the Global India Foundation (www.globalindiadoundation.org), a round table consultation meeting was held at the India International Centre, New Delhi on Wednesday the 8th September, 2010. Global India Foundation organized the meeting, acted as hosts and provided all the facilities including hospitality for the participants. About 50 participants from local, national and international organisations were present.

7.2 Members of the Executive Council ,Staff and Associates of Global India Foundation(GIF) , were joined by representatives from Liverpool School of Tropical Medicine(LSTM), Royal College of Obstetricians and Gynaecologists(RCOG), Rotary International , International Fellowship of Rotarian Doctors(IFRD), World Health Organisation(WHO) , Government of India (GOI) Ministry of Health and Family Welfare, Federation of Obstetric and Gynecologic Societies of India (FOGSI). Additionally, Director and Executive Members of the National Institute of Health and Family Welfare (NIHFW), New Delhi and All India Institute of Medical Sciences (AIIMS), New Delhi were invited and were represented

7.3 The aim of the meeting was to have *exchange of data and ideas so as to formulate a practical framework of maternal mortality reduction strategies in South Asian Region.* It was envisaged that organizations representing the main participants would work as a group and contribute to effective and sustainable measures based on their respective areas of expertise.

7.4 A steering Group representing the various organisations will work under the auspices of Global India Foundation and will agree to coordinate efforts , monitor progress and assist in activities of individual organisation ,wherever possible .

7.5 The aim of the group will be to *help increase the proportion of institutional delivery, and delivery by skilled birth attendants in selected parts of India. It will work towards supporting and enhancing infrastructure at local levels, as well as promoting social mobilization, women's empowerment and reduced gender inequality*.

7.6 The activities may consist of support of training, provision of drugs, equipment, transport, infrastructure and policy issues, through funding and advocacy roles.

8. Presentations

There were nine prominent speakers in the round table consultation, on the 8th September, 2010

Admiral P J Jacob from Global India Foundation (Chairman) welcomed the guests and spoke about the foundation, outlined its objectives and activities and also set the context for the round table.

Dr. Niranjan Bhattacharya, a distinguished Gynaecologist and also from GIF spoke about maternal and child health from the point of view of a gynecologist, highlighting the fact that the issue of maternal mortality cannot be solved by gynecologists alone.

Sociological factors like the value of a woman's life and her social standing, lack of education, infrastructural issues like poor quality of roads, inadequate medical services in remote areas etc are factors which reiterate the need for various players who influence these factors to work together.

MMR is also prone to mis-calculation and statistical errors and organizations need to come up with a way to standardize and correct this globally.

Dr Narimah Awin (WHO) Regional Adviser for Maternal and Reproductive Health, World Health Organization outlined the importance of educating the family, of the value of the mothers life and reiterated the importance of collaboration between various agencies She said the biggest problem in India faced by WHO is scaling up operations and programs because India is such a diverse and geographically complex country. One of the areas where doctors and scientists can collaborate with organizations like WHO is sharing and putting to use tools created by WHO which will improve data gathering and quality of data.

Dr Nynke van den Broek, **(LSTM)** Director in Sexual and Reproductive Health, Honorary Consultant Obstetrician Gynaecologist, Liverpool School of Tropical Medicine said that in order to fully understand the issue of maternal health, one must go beyond

statistics and look at real life experiences. A complication in pregnancy or delivery has a terrible negative effect on the mother and affects the whole family, the community and the country. In a developing country, a new mother faces a 1 in 70 to 1 in 2000 life time risk of this happening which is very high. In a developed country this could be 1 in 7000.

She highlighted the work LSTM is undertaking in collaboration with RCOG, WHO and the British Government (UK AID) in many countries including India. This consists of training the Trainers in Obstetric emergencies, Resuscitation and Deliveries. The Trainers then train skilled birth attendants and others working in remote parts of the country

Any collaboration should work towards scaling up these and similar programmes and ensuring high percentage of deliveries by skilled birth attendants .She also stressed upon the role of the Government and while GOI has various successful programmes targeted at reducing maternal mortality, they all need further expansion of the programme and coordination because India is a vast country and time is running out before 2015.

Dr Urvashi Jha (**RCOG**) Chairperson North Zone India, Royal College of Obstetricians and Gynaecologists spoke about the importance of training cascades and possibilities involving ROCG in this collaboration.

She said ROCG can contribute by providing training, family planning and adolescence care. She said more global funds need to be channeled towards Maternal Mortality reduction strategies. RCOG has a friendly relationship with FOGSI. The two organisation can and should work together – India is a big country and the needs are great .Training is something the College is working towards improving women's health

Dr. Himansu Basu (IFRD) a past Governor of Rotary International, Past Chairman of Rotarian Doctors Fellowship and UK Chairman of Rotarian Action Group on Population Development, spoke about the complex global problems and background leading to maternal death.

For those who survive, there is a fifteen to twenty fold increase in complications leading to ill health. The background and risk factors include Poverty, Illiteracy, childhood marriage, and of course complications of pregnancy and childbirth. Training the trainers who in turn train the basic health workers in obstetric and emergency skills, is all important but on its own is not enough. Basics of antenatal care and preventive medicine should also be included ,without making the training too complicated

Not only must the skilled birth attendants receive up to date training, but also the number of skilled birth attendants should increase substantially to provide effective cover. He emphasized the need for a new cadre of community midwives being established by the Government. Good antenatal care, adequate food, provision of electricity, water, sanitation, hygiene, adequate emergency transport, drugs and equipment can also be in short supply. There is a need for social mobilisation against child marriage, promoting basic antenatal care, acceptance of institutional and skilled birth attendant care - these are

important areas in which collaboration with Rotary at grass root level can represent very successful investment.

Dr Basu put forward a proposal to undertake Pilot Studies in selected areas in India where there will be available a full complement of trained skilled birth attendants and full access to institutional deliveries (following the GOI training initiatives currently in place). Local deficiencies in infrastructure, transport, equipment and medicine in these areas, would then be identified and corrected. *He suggested a tripartite partnership between the Government, Professional bodies and Rotary International (Maternal and Child Health is an established area of focus in Rotary Service) to establish this Pilot in selected provinces in India identified by the Government (areas with high penetration of GOI's training the trainer model) and Rotary International (incorporating the Rotary Foundation Future Vision Pilot Districts*). *Social mobilization by Women's Groups will also be important* local *initiative. GIF could act as a facilitator for this model*

Shri Sushil Gupta (Rotary International) Padmashree and Past Director, Rotary International spoke about Rotary's successful Global Polio Eradication Programme ,which is nearing its successful completion. Only 4 endemic countries remain infected with wild Polio virus The success is due mainly to massive collaboration between Governments, WHO, UNICEF, Benefactors such as the Gates Foundation and of course Rotary International which continue to provide funding as well as hands on efforts of its worldwide membership. Rotary International is capable of replicating the success of Polio Eradication to Maternal Mortality Reduction Strategies.

As an interim measure, a successful model of identifying poor performing areas, forming a task team with a rotary representative in each area, cooperating with organisations providing professional expertise and equipment and filling up a gap in the provision of drugs, equipment and other resources at the grass root level, can work well.

Rotary Polio Volunteers are currently equipped with cell phones which can also monitor cases of obstetric emergencies and assist in coordination which can help transfer information faster and prevent deaths due to delay and inadequate transport. Rotary International can use its extensive network of highly influential members for advocacy and creating awareness.

Dr. Himanshu Bhushan (**GOI**) Asst Commissioner (Ministry of Health and Family Welfare), Government of India spoke about various government initiatives and challenges ahead in the area of Maternal Mortality Reduction. He mentioned that while technical strategies (this includes the successful training the trainer's model in emergency and obstetric care) are in place through the National Institute for Health and Family Welfare (NIHFW) and funds have increased towards this cause, there is a huge gap at the ground level, especially in quality of care.

The Government's aim is to increase the proportion of deliveries at institutions and under care of skilled birth attendants. While most people talk about using new advances in communication technology to improve health care outcomes, this is only possible in

states where communication technology is available in remote areas. The government needs partners to achieve results and public-private partnership with private health care providers is the way forward.

He also spoke about the role the media plays in projecting the image of the government in health care. He said media need to report success stories and effective programs to encourage mothers to utilize government services. The government especially needs help to reach out to the corporate sector to contribute wherever possible. As far as political will goes, the Prime Minister of India is personally monitoring performance of each state for crucial health care indicators like maternal and child mortality and family planning.

He spoke about other collaborations, such as the recent one with Public Health Foundation of India which centers on quality of care which can possibly be integrated into this collaboration.

Dr. Mala Aurora (FOGSI) Vice President Elect, Federation of Obstetric and Gynecological Societies of India said FOGSI is the largest professional organization of Gynecologists and Obstetricians in India and any meaningful outcome in this area has to be carried with the involvement of this organization.

FOGSI has maternal mortality cells through which it can implement various initiatives. She said private sector hospitals need to be in the loop with Primary health centers and government general hospitals for a better flow of information and FOGSI needs to improve collaboration with other bodies in areas where it has little control like illiteracy. Maternal Mortality cannot be reduced without addressing these factors.

She also stressed the importance of collaboration with many of the agencies present at the meeting, particularly women's social groups which can be particularly useful in social mobilisation on measures aimed at reducing MMR.

Open Discussion –there was a lively discussion from participants

Several noteworthy comments and observations were also made by the participants in the round table. **Prof S P Narang** spoke about public perception and the role of the media in creating an image of the health care system. **Prof Kapil Kumar** said sensitivity to woman's health and role of woman needs to be created from the school level. Maternal health should be a fundamental right.

Mr. Tapan Chakarbarty, former Member of Parliament said as a former member of the government he is aware that most programs are at the political level and are failed to be implemented correctly. He said that each Member of Parliament act as spokespersons and representatives of several hundred thousand of people in India and they can be the most effective carriers of this message.

Dr. David Goodall spoke about the role of the enabling environment including social, medical and economic factors - maternal mortality is not a stand alone issue.

Prof. Maitreyi Kollegal of International Institute of Health management Research said woman self help groups that have been created by the Government of India to promote economic independence for women can be used also to create awareness on preventive care and family planning, pre natal care and importance of institutional delivery, birth spacing etc. She said these groups meet every week in the village centres and such a vast social network has a tremendous potential. Examples of these groups include Stree Sakti, or Saheli centres

Dr. Neera Dhar of the National Institute of Health and Family Welfare spoke about *scaling up the midwifery courses and training a new cadre of midwifes*. Also harnessing the knowledge of the existing midwifes at the village level which is in danger of being lost. While the cities have the presence of good quality doctors, such facilities are not available at the peripheries. This is an area that FOGSI can help with.

Prof Omprakash Mishra summed up the discussion and spoke about constituting a team to take the lessons learnt forward.

Dr. Niranjan Bhattacharya then read out the names of the members of the team

9. Resolution of the meeting

In depth discussions involving many aspects of this problem and how to reduce MMR, resulted in a unanimous decision of forming a steering group headed by Dr Himansu Basu.

The suggested members of the steering Group are

Dr Niranjan Bhattacharya *Advisor & Sr. Consultant in General Surgery and Ob/Gyn at Advanced Medical research Institute, B.P. Poddar Hospital, Calcutta*
Dr Himansu Basu, *Consultant Gynaecologist, UK ,past Governor of Rotary International ,former Chairman, International Fellowship of Rotarian Doctors*
Dr Narimah Awin, *Regional Adviser for maternal and reproductive health (MRH), World Health Organization*
Dr Nynke van den Broek, *Senior Clinical Lecturer in Sexual and Reproductive Health, Honorary Consultant Obstetrician Gynaecologist, Liverpool School of Tropical Medicine*
Dr. Himanshu Bhushan, *Asst. Commissioner (Maternal Health), Government of India Ministry of Health and Family Welfare*
Dr Urvashi Jha, *NCR Chairperson North Zone India, Royal College of Obstetricians and Gynaecologists*
Padmasree Sushil Gupta, *Past Director , Rotary International*
Dr. Mala Arora, *Vice President Elect, Federation of Obstetric and Gyaecological Societies of India*
Miss Ziba Mirza, *Research Fellow , Global India Foundation*
Prof Omprakash Mishra, *Member Secretary, Global India Foundation*

The aims, objectives and action plans will be developed further following input from the interested organisations which participated at the round table forum

The Groups activities will be under the auspices of the Global India Foundation in its different offices in India and abroad. Electronic means of communication will be used

The steering group will endeavor to seek support from Govt of India Officials including the Minister of Health ,Funding Organisations like ICMR etc as well as non Govt funding and Policy making bodies. like WHO.

Rotary International is to be approached for assistance with pilot projects to be prepared by the Committee.

The Committee also keeps the right to appoint Global experts as Consultants and co-opt other suitable members as and when needed.

10. Summary and Conclusions

10.1 Maternal Mortality Ratio is high in Africa and South Asia. In each region ,there are wide variations in MMR

10.2 Causes of maternal death are complex and includes medical, social, economic and cultural factors

10.3 Generally high MMR is associated with poverty, illiteracy, malnutrition, anaemia and diseases such as Malaria, HIV etc

10.4 Within these regions, some areas have been able to lower MMR ,the examples being Sri Lanka, Tamil Nadu and latest Nepal. There are lessons to be learnt from these success stories.

10.5 Institutional deliveries and delivery by trained and skilled Birth Attendants will have substantial impact on the lowering of MMR

10.6 Provision of antenatal care, food, shelter, medicine, emergency transport, infrastructure such as electricity, communication is important

10.7 A meeting of Parliamentarians from a number of countries in 2009 highlighted many of these problems and suggested remedial actions

10.8 At a recent meeting held in Delhi (September 2010) ,representatives from a number of stake holders agreed to collaboration ,formed a steering group and charged the group to investigate the possibility of a Pilot study in some parts of India.

10.9 The details of collaboration will be worked out. But a starting model should have the involvement and support of

a. The Government of India (and possibly benefactors and philanthropists) who will consider identifying suitable areas in India ,funding the Pilot Projects, instituting policy changes and providing an ongoing framework for incorporating the improvement and advances
b. Professional bodies such as FOGSI, RCOG and LSTM who should consider involvement in Training the Trainers Scheme funded by grants from (a).The Training model should not be “cloned”, but reflect adaptation to the Indian situation.

c. Rotary International, because of its grass root involvement, can and should be asked investigate the availability of emergency transport, other resources such as Blood Bank, electricity, water Sanitation Hygiene amongst others.
d. Organisations representing women's interests such as Saheli, Centres, Sama or the White Ribbon Alliance who can assist in social mobilisation and promotion of the concept

10.10 The organisations included in 10.9 should be requested for their involvement and contribution to the action listed above. GIF would act in support and Coordinator roles.

"One pregnant woman dies every minute ……"