Ensuring women's access to EmOC:
the UNICEF experience

Marilen J Danguilan, MD, MSc, MPP

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Our Common Goal

MDG goal:

To reduce maternal deaths by 75 per cent by 2015

Programs: a review

- Training of TBAs
- Antenatal Care
- Skilled Attendants
- Emergency Obstetric Care

TBAs

- Provide cultural and social support
- Technical skills are limited
- Cannot prevent maternal deaths

TBAs

- **For example, in Bangladesh TBAs were trained by BRAC to perform clean deliveries.**

- **But an evaluation showed that, even though they used the training, postpartum infections did not decline. (Goodburn et al, 2000)**

Antenatal Care

- **It is almost impossible to predict accurately which woman will face life-threatening complications**

- **Many antenatal routines have not been effective in preventing complications**

In Short ...

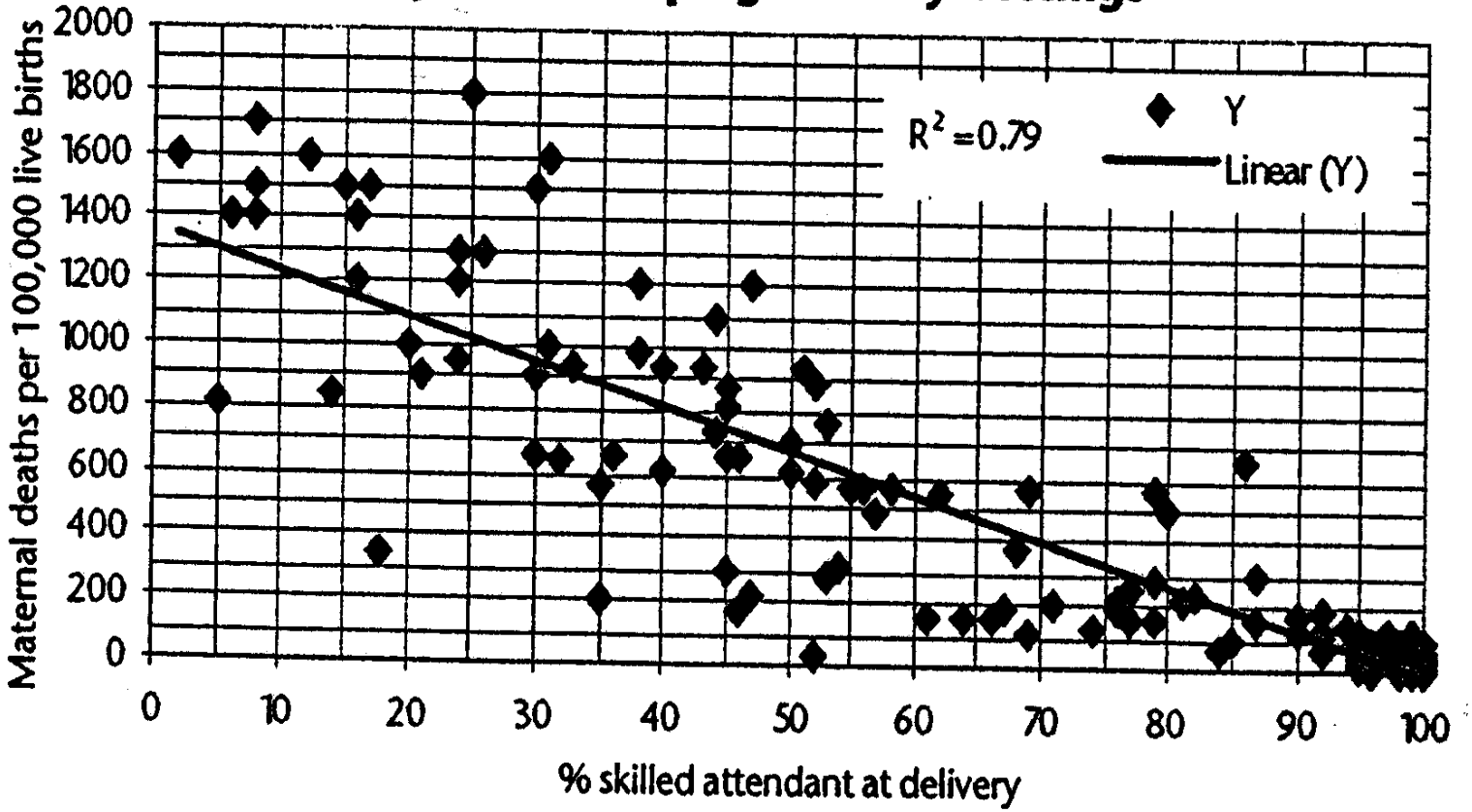
Once a woman is pregnant
most serious obstetric complications
cannot be predicted or prevented,

but they can be treated.

Skilled Attendants

- **To ensure that every pregnant woman has a skilled attendant to attend to her is desirable.**
- **The overall effectiveness of a skilled attendant is dependent on access to emergency obstetric services or EmOC.**

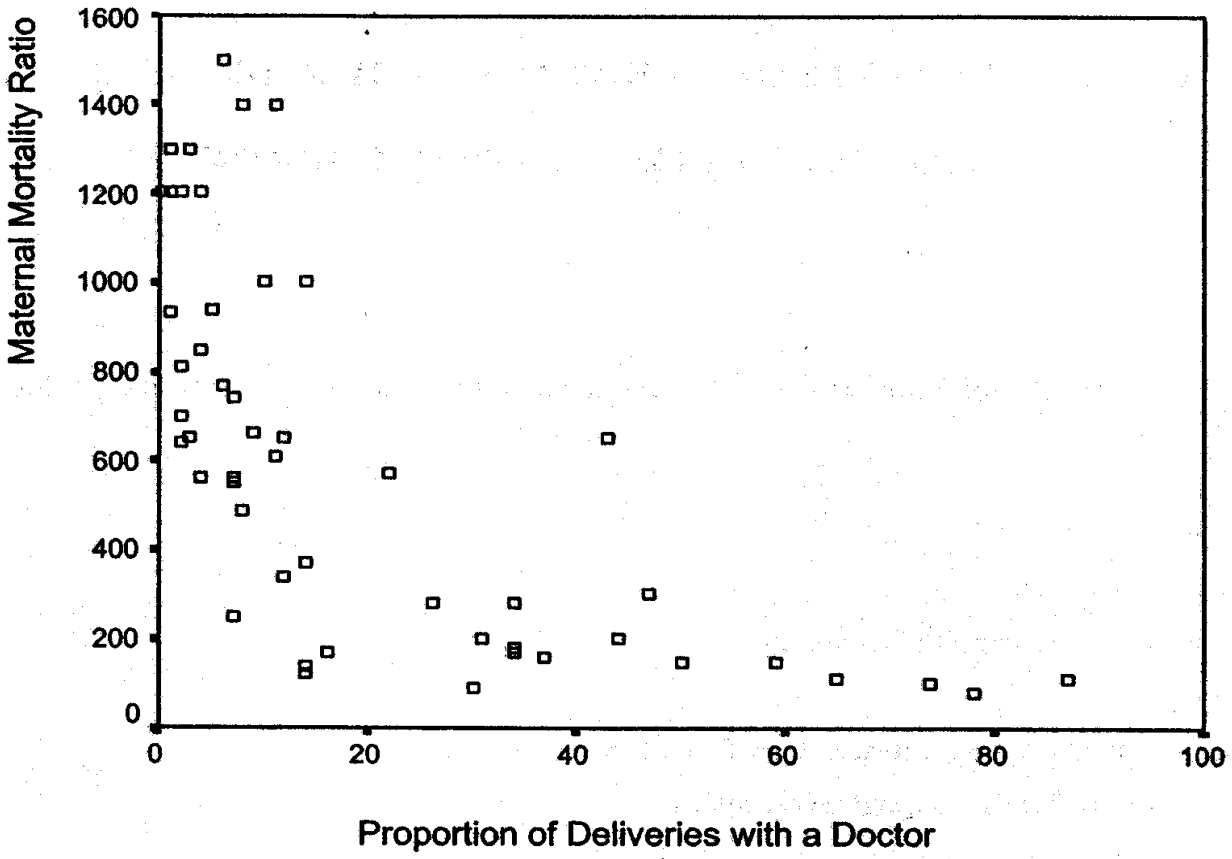
Figure 1: Relationship between skilled attendant at delivery and maternal mortality in developing country settings



Source: AbouZahr, C. Monitoring progress towards the goal of maternal mortality reduction. WHO, 1998.

Source: Saving Lives: Skilled Attendance at Childbirth, WC Graham, 2000.

FIGURE 6 PROPORTION OF DELIVERIES WITH DOCTORS AND THE MATERNAL MORTALITY RATIO FOR 50 DEVELOPING COUNTRIES, ~1990



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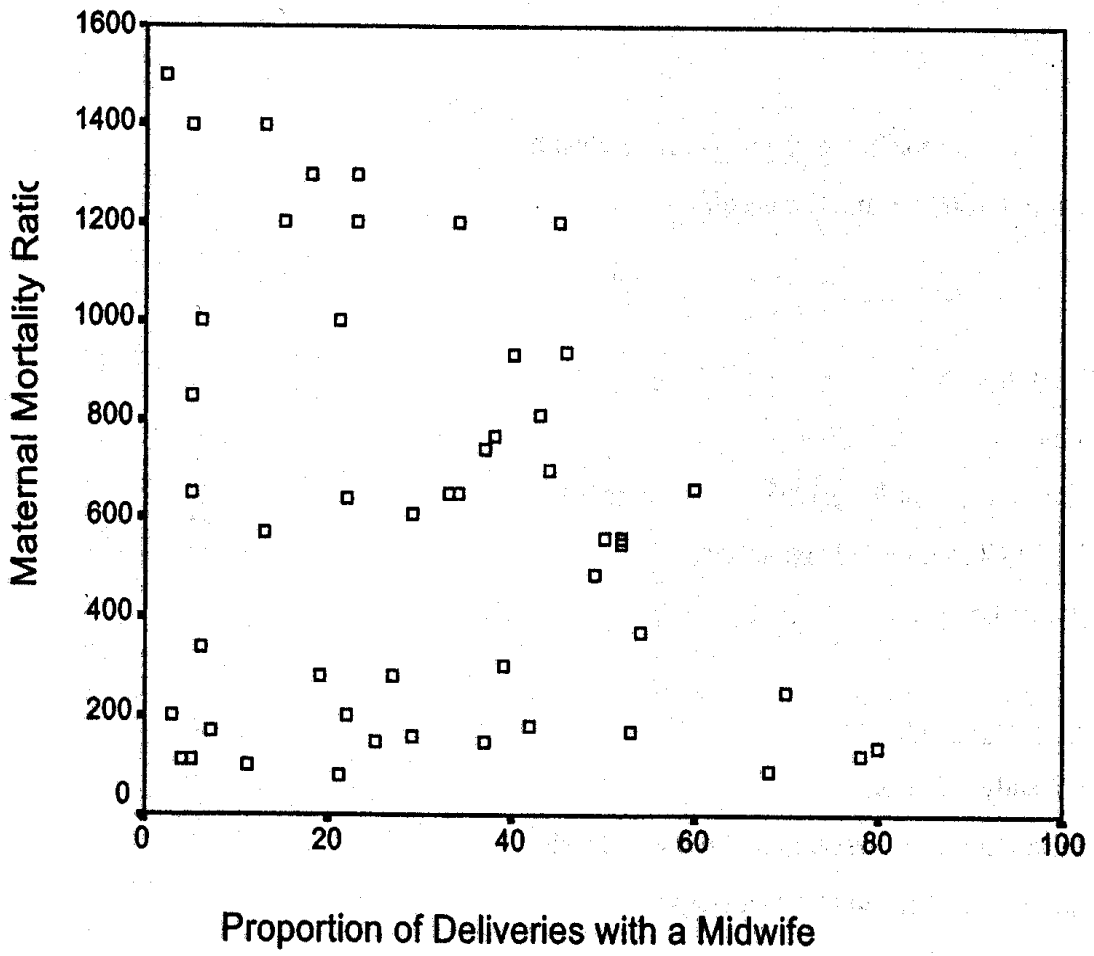


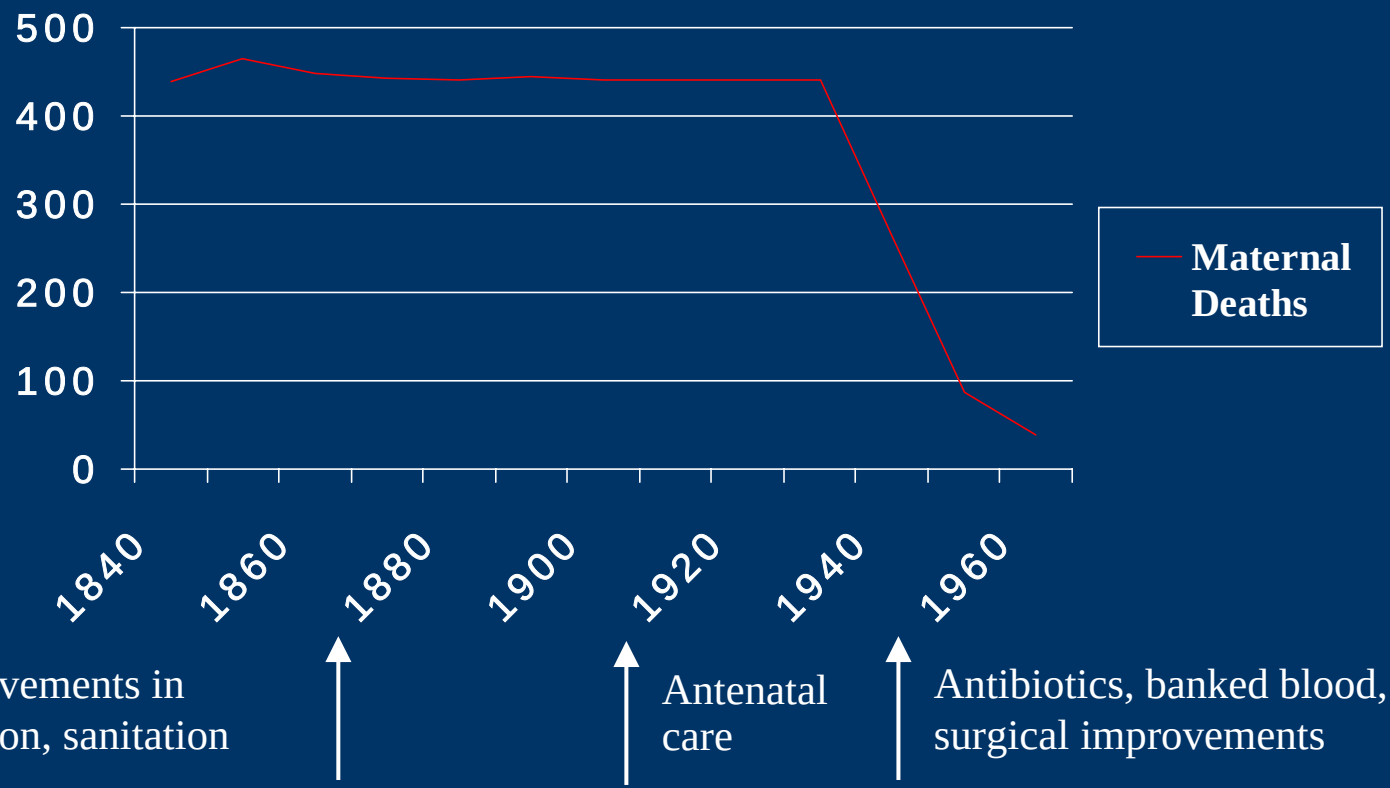
FIGURE 7 PROPORTION OF DELIVERIES WITH MIDWIVES AND THE MATERNAL MORTALITY RATIO FOR 50 DEVELOPING COUNTRIES,~1990

Source: Saving Lives: Skilled Attendance at Childbirth, W. Graham, 2000.

Emergency Obstetric Care

- provide parenteral antibiotics, uterotonics, and anticonvulsants (Mag Sulfate)
- perform manual removal of placenta
- conduct assisted vaginal delivery
- perform CS when indicated
- provide blood transfusions

Maternal Mortality: UK 1840–1960



Maine 1999.

Maternal Mortality in Sweden

- 1751 to 1920: rate of decline was slow -- era of the midwives
- 1920 to 1980: decline was at a much more rapid pace (2% per year)
- By 1980, Sweden recorded fewer than 10 maternal deaths per 100,000 live births.

MMR in Sweden

This coincided with:

- cesarean section
- introduction of antibiotics
- blood transfusions
- legal safe abortions

The Paradigm Shift

From:

If we take very good care of pregnant women, they will be okay.

To:

All pregnant women need access to EmOC.

Our duty to provide what works

Evidence-based programming is rights-based programming.

A maternal mortality example

3 options for treatment of obstetric complications:

1) training and equipping TBAs
2) upgrading health centers
3) upgrading district hospitals

Can it be done?

Is it feasible to have district hospitals provide EmOC?

Country studies have shown this is possible.

The South Asian experience has shown it is feasible.

Feasibility

Problems with health facilities:

- keeping trained staff
- keeping supplies in stock
- providing supervision

Feasibility (cont.)

These same problems apply to community-based programmes,

BUT there are 10-100 times more TBAs than hospitals or health centers.

Feasibility (cont.)

If it is very difficult to provide supplies and supervision to 50 district hospitals,

how will it be possible to do so for 5000 TBAs?

Cost

A key distinction =

between “unit cost” and “program cost”

Example: a “unit” can be the cost of training 1 TBA or 1 doctor

Cost (cont.)

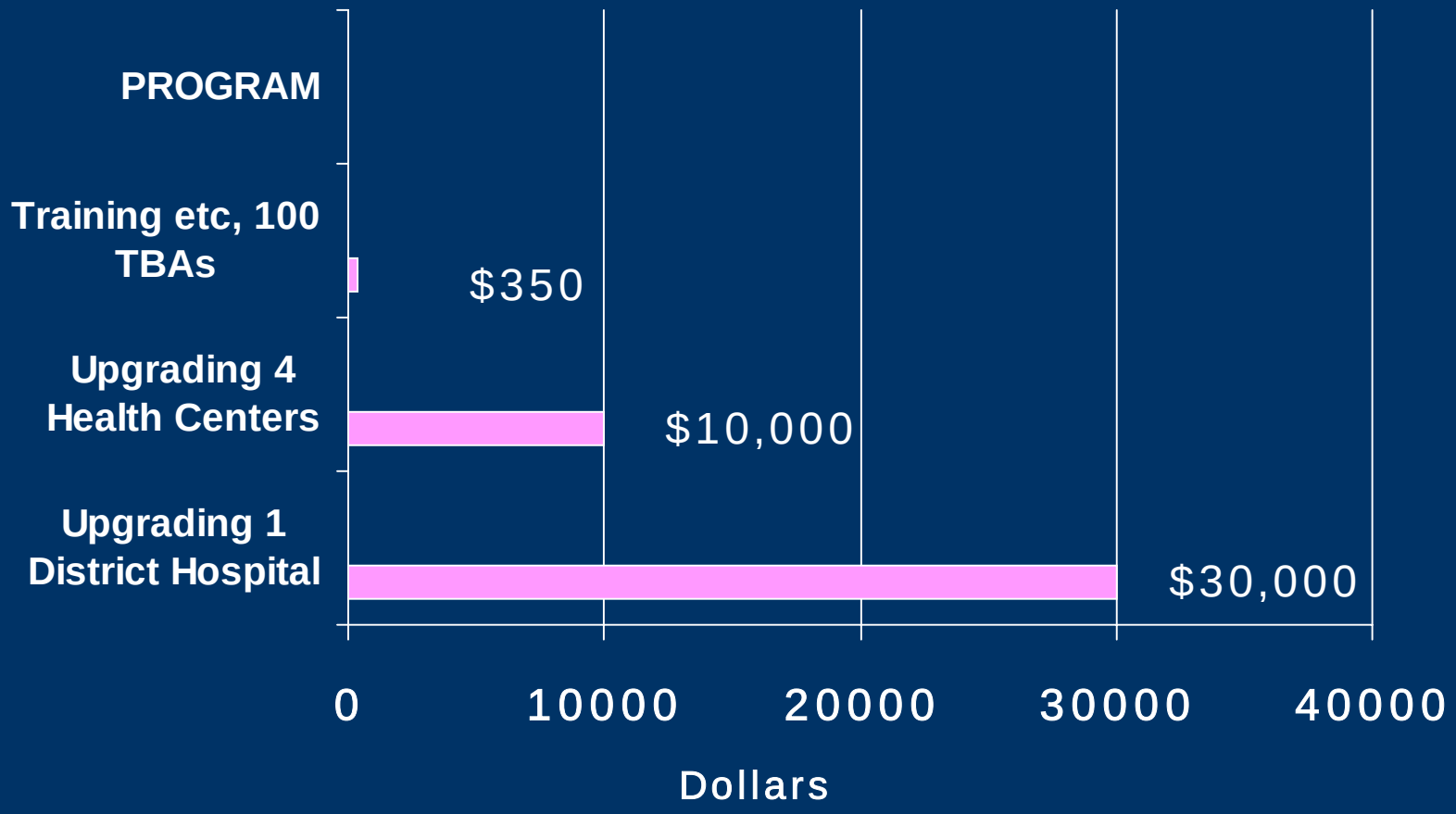
Program cost =
cost per unit x number of units

Cost (cont.)

Suppose, for this example, it costs :

- $350 to train, etc. 1 TBA
- $10,000 to upgrade 1 health center
- $30,000 to upgrade 1 district hospital

Estimated unit cost

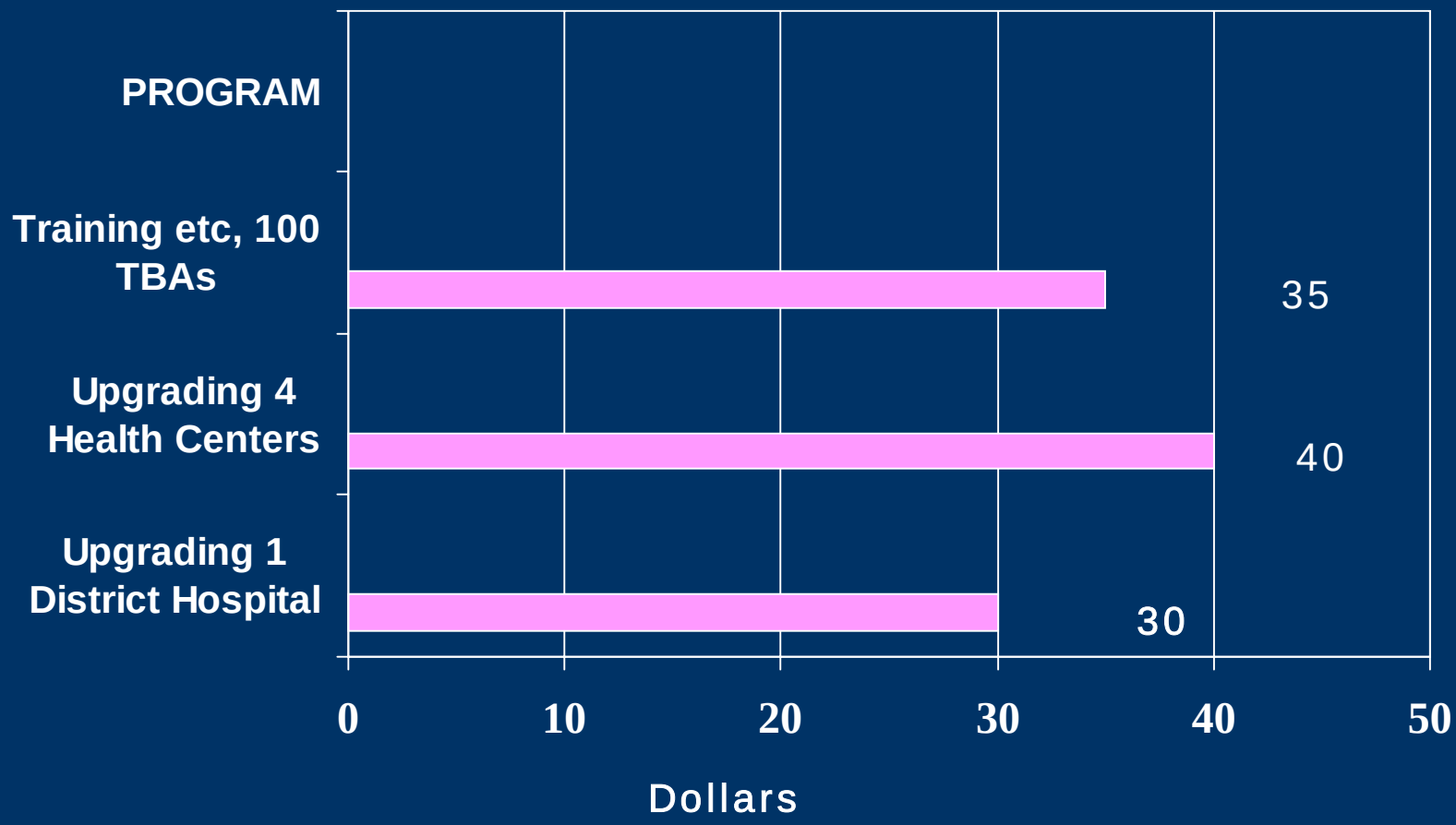


Cost (cont.)

And suppose, per district, there are:

- 100 TBAs
- 4 health centers
- 1 district hospital

Estimated programme cost (in $000s)

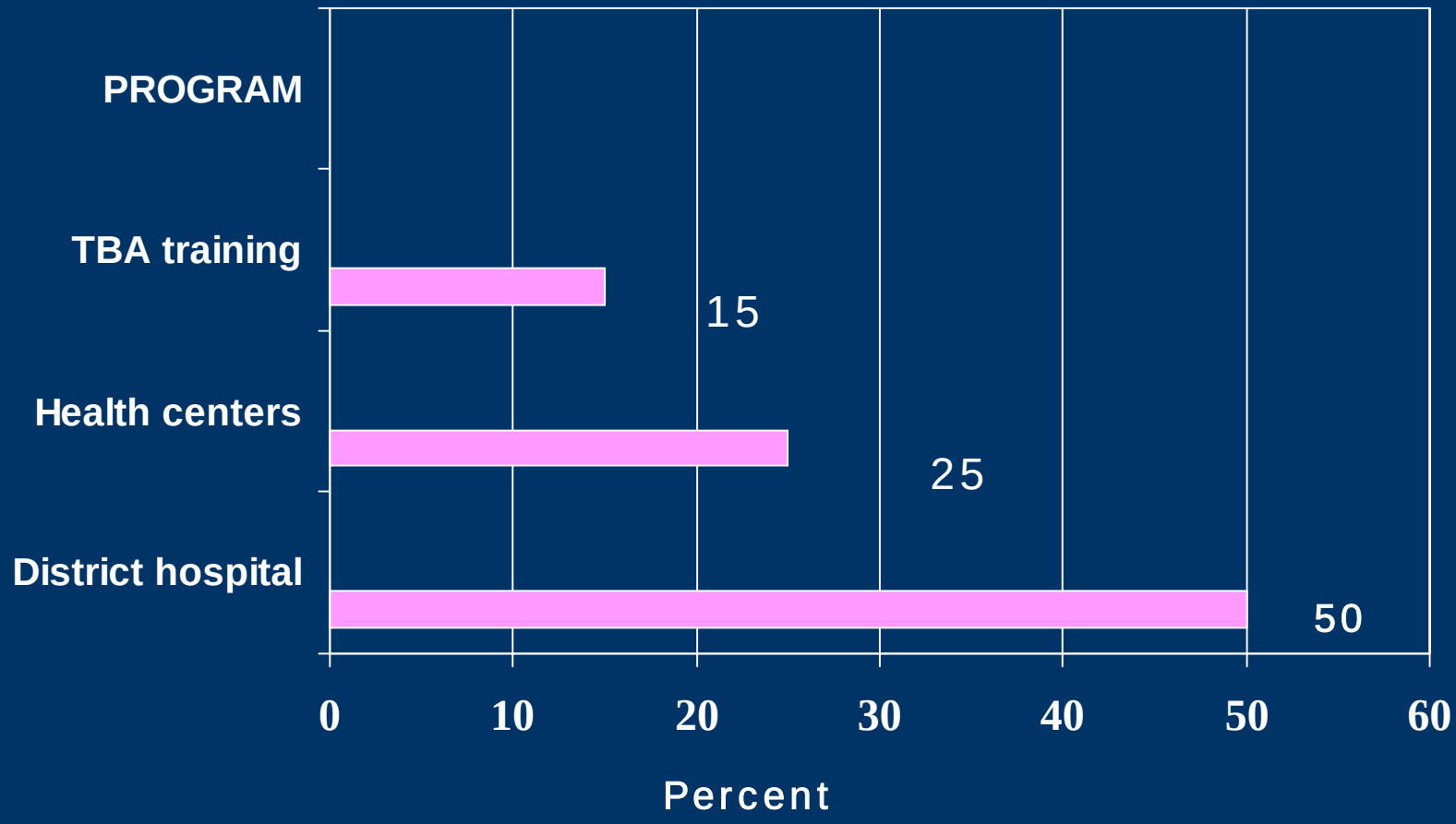


Cost-Effectiveness
(cont.)

To continue our example,

suppose that the effectiveness in preventing deaths from obstetric complications is as follows:

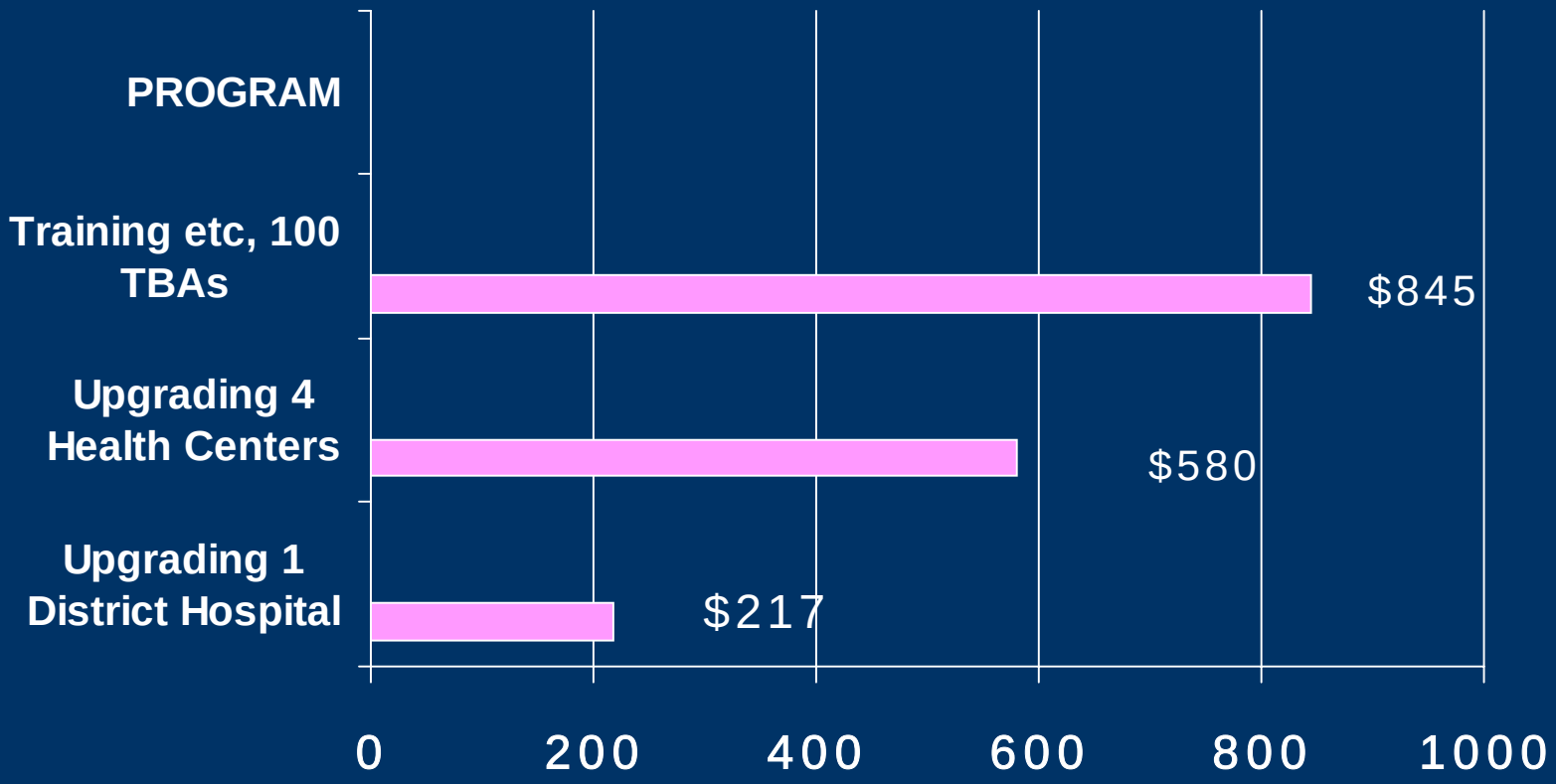
Estimated obstetric deaths prevented (%)



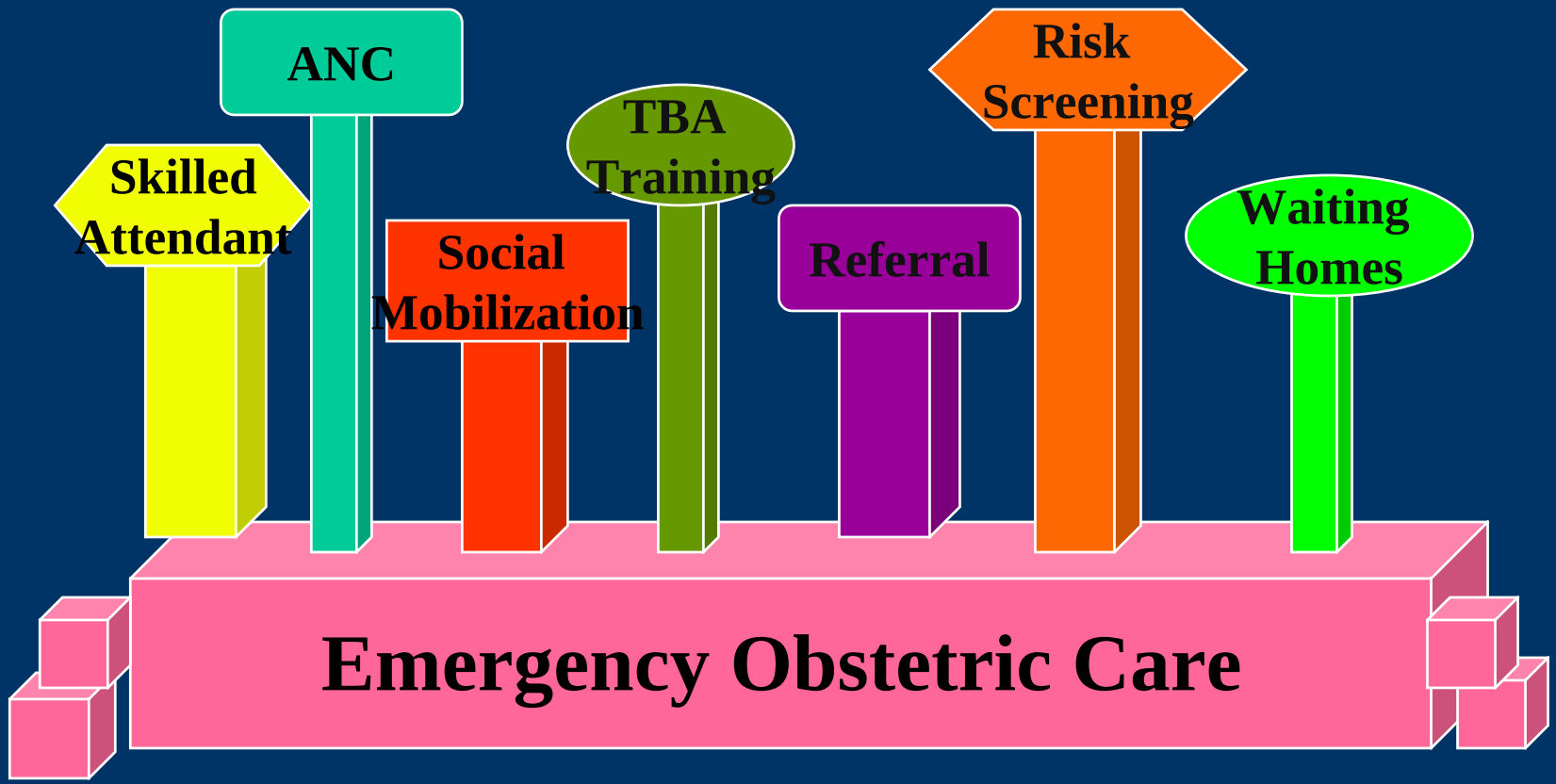
Cost-Effectiveness
(cont.)

Then, the cost per obstetric death averted would be ....

Estimated cost per death averted ($)



EmOC is the foundation



In Bhutan

- Increased coverage of basic and comprehensive EmOC
- 8 Comprehensive and 14 Basic EmOC centers established, functioning round the clock;
- 6 Comprehensive EmOC centers have blood storage facilities

In Bhutan

- Met need for EmOC increased from 4 % to 49 %
- CS as a percentage of all births has increased from 1.28 % to 3 %
- Case fatality rate has decreased from almost 2 % to 1.3 %

In Sindh, Pakistan

- Increased coverage of Comprehensive and Basic EmOC
- Availability of CEmOC on a 24-hour basis
- Competency-based training on EmOC

In Sindh, Pakistan

Sanghar District:

- **Percentage of births in facilities increased from 5.1 % (2000) to 8.7 % (2002).**

- **Average Case Fatality Rate is 1.5 %.**

In West and Central Africa

- Benin, Chad, Guinea Conakry, and Mali
- Nationwide needs assessments on EmOC

In East Africa

- Reduction of maternal mortality is one of the top priorities in Uganda
- Ministries of Health in Ethiopia, Eritrea, and Kenya have adopted plans of action to implement EmOC

In the Horn of Africa

Djibouti, Sudan, and Somalia have adopted plans of action to pursue EmOC as their core strategy in reducing maternal deaths

Conclusion

In light of resource constraints, all priorities are not created equal.

Conclusion

It is our duty to inform Governments and civil society about the evidence.

It is likewise our duty to ensure that this evidence is applied to save women’s lives.