

A Silver Lining in Dark Clouds !



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I happened to attend the dissemination of the “Nepal Maternal Mortality and Morbidity Study 2008/09” on 23rd November 2009 at Kathmandu as one of the representatives from a private medical college.

Reducing maternal morbidity and mortality is a great challenge in a country where the geo- political conditions are not favorable.

The study done in 2006 Nepal Demographic & Health Survey (NHDS, 2006) indicated reduction in maternal mortality ratio (MMR) compared to the study done by first MMR study in 1998 in which the MMR was estimated at 539 maternal deaths per 100,000 live births. This report attracted the attention of stake holders of the country and abroad to reduce the figure.

The government of Nepal supported by DFID and USAID decided to conduct a study on MMR (2008/09) to see whether Nepal is on the right track to meet the millennium development goals (MDG).

The study area included eight selected districts to ensure a balance of mountain, hill and tarai representation from all five development regions. The population comprised of 12% of Nepal’s population – 3,298,319.

Components of the methodology of the study were community verbal autopsies, live birth identification, facility assessment, staff competency assessment, maternal death review of the hospitals, interviews with formal providers, interviews with women in the community, focus group discussion with women in the community who had delivered in the last 10 years, key stake holders – in depth interviews, interviews with informal providers and EOC morbidity

monitoring (CEOG & BEOC facilities). These parameters covered both qualitative and quantitative aspects.

Overall MMR for eight districts was found to be 229 per 100,000 live births. Maternal death accounted for 93% of pregnancy related deaths, so the pregnancy related mortality ratio was 277/100,000 LB which makes a good proxy indicator for maternal mortality and is consistent with the 2006 NDHS figure of 281 deaths per 100,000 LB.

The MMR was more prevalent in women aged less than 20 years and between 30-34 years. Ethnicity also counted as a factor with higher rates among Muslims, Tarai/Madhese and Dalits. It could be due to their socio-economic status & some cultural taboos.

“External causes of morbidity and mortality” was ranked the number one cause of death – which was ranked second in the 1998 study (13%). This change was due to an increased number of suicides which was 16% of deaths. This reflects that the women are facing “domestic/external violence” leading them to commit suicide.

Although maternal death due to haemorrhage has come down from 41% (1998) to 24%, we still need to focus our attention on eclampsia – the second leading cause (21%, increased from 11% 1998) which was preventable but it so happened due to the lack of availability of magnesium sulphate. Complications related to abortion remain the third (7%) cause of maternal death with half due to induced and half due to spontaneous abortion. Obstructed labour 6% (down from 13% in 1998) and puerperal sepsis 5% (down from 11% in 1998) account as other causes.

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The MMR of 267 per 100,000 live births in the hospitals whereas in the EOC facility it was 218 and the direct cause was 14 per 100,000 live births.

All the government hospitals, 83% non government hospital and 31% of PHCCS had magnesium sulphate in stock but 25%, 17% & 31% respectively had no stock of the drug at the timing of survey.

Retained placenta, obstructed labour also contributed in maternal death. Death due to puerperal sepsis was lower than 1998 contribution to all hospital death was higher (9%) than in 1998.

Of 10 sites supposed to provide CEOC services only 9 were fully functional.

Human resources: there was unfilled sanctioned posts especially frequent transfer, staff on leave, deputation

and training and high patient load. Mountain and hills districts suffer more due to lack of human resources. To date only 1082 providers had received national SBA training. Infrastructure, drug supply and equipment conditions also not very satisfactory to cope with the problem.

To conclude

making right decision timely is the prime element, which can be germinated within our own self, aiming at a good quality service delivery with best of our efforts by ensuring health needs and adequate essential supplies, in order to achieve MDG in targeted time. The efficacy of service regarding ante-partum or postpartum haemorrhage has to be improved by training all the service providers as haemorrhage and eclampsia have been identified as important causes of maternal deaths. Manual vacuum assitation (MVA) training has to be provided in large scale.