
Maternal Mortality in Pakistan

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Worldwide the maternal mortality is decreasing. An estimated 289,000 maternal deaths occurred in 2013 which was 45% lower than that reported in 1990, the year in which the Millennium Development Goals (MDGS) were set.¹ In Pakistan, during the same period there has been a decline of 57%. Nevertheless, Pakistan continues to be recognized in the zone of countries with high to very high mortality. Ten countries that account for 58% of all maternal deaths in the world include India (17%), Nigeria (14%), Democratic Republic of the Congo (7%), Ethiopia (4%), Indonesia (3%); Pakistan (3%); United Republic of Tanzania (3%), Kenya (2%), China (2%), Uganda (2%).¹

According to Pakistan Demographic and Health Survey (PDHS) 2006-2007, the National Maternal Mortality Ratio is 276. Nevertheless, there is a wide variation between Provinces – Punjab 227, Khyber Pakhtun Khwa 275, Sindh 314, and Baluchistan 785. Difference between Rural and Urban areas is also very marked, the MMR being almost twice as high in rural areas (319) than in urban (175).^{2,3}

Trends in maternal mortality 1900-2013, a paper published by WHO, estimates the MMR for Pakistan for the year 2013 as 170 with a level of uncertainty between 93-320¹, while Global Burden

of Disease estimates the MMR for Pakistan at 400.6 with uncertainty between 233– 560.8.⁴

The variations in MMR values may be attributed to variations in study design, methodology opted, data collection and location (rural /urban). In fact measuring MMR is problematic because the approaches available are complex and need intensive resources.

In Pakistan, Maternal Mortality measurement remains a challenge as record keeping of maternal deaths and system of reporting is weak. There is lack of vital registration and poor certification of cause of death.

Nevertheless, to address maternal mortality, calculating Maternal Mortality Ratio or rate is not enough. It goes beyond measuring the level and the number. We need to know the underlying cause as to why maternal deaths occur and how can they be prevented.

PDHS showed that maternal deaths constitute 20% of all deaths in females of reproductive age group. Post Partum Haemorrhage (PPH) was the leading direct cause of maternal deaths responsible for 27.2% of deaths. Infact, Haemorrhage, both antepartum and postpartum, caused deaths in almost one third (32.7%) of the women². In a study of mothers who were brought

dead to Jinnah Postgraduate Medical Centre, Karachi almost 50% of deaths were due to PPH.³ Preeclampsia/eclampsia accounted for 10.4% of the maternal deaths whereas abortions were found to be responsible for 5.6 percent deaths. Abortion deaths were however considered to be underreported because of the stigma attached to abortions. Among the indirect causes of maternal deaths, liver failure due to hepatitis was the most common.²

One of the disturbing facts in the PDHS report was the number of deaths that were classified as iatrogenic i.e. due to improper management and negligence in hospital settings. This included mismatched blood transfusions and general anesthesia complications.²

In addition to medical causes, socio economic, psychological and cultural factors affect maternal health. These include poverty, lack of education, poor nutrition, lack of family planning, domestic violence, gender discrimination, and access to quality care especially during labour.

An in-depth analysis of deaths of women of reproductive age from 2006 – 07 highlighted the causes other than medical including some of those mentioned above. These included poverty, neglect by an unsupportive family, domestic violence, gender discrimination, superstitions and ignorance. The psychological, social and cultural factors influence women's lives and well being, creating a barrier in seeking appropriate and timely care.⁴

What needs to be done?

There are many challenges.

As maternal mortality results from a range of medical as well as non- medical causes, the actions have to be diverse.

All those concerned i.e. the civil society, the NGOs and the Government in particular have to work together. Improving the economic status of women, providing access to education especially for women, improving their nutrition and increasing access to quality health care, especially during pregnancy need immediate attention. The laws prohibiting early marriages need to be enforced vigorously. Inequalities in access to maternal care should be removed. Financing for maternal care needs to be considered seriously.

Strengthening of primary care facilities is essential so that quality antenatal care, post-partum follow-up, family planning, nutrition and health education services are provided to women.

In-service training to maternity care providers for better diagnosis and treatment in referral facilities and for improving management to reduce delays, is crucial. Together with that improving and upgrading Emergency Obstetric Services is mandatory.

Attention should be focused on the first day of delivery because that is the time when most mothers and babies die. Midwives who are trained, competent, aware of the regulations and are supported by a strong referral system can provide the much needed care to the women in rural areas.

The system of reporting and record keeping especially of maternal deaths needs to be strengthened. Measures should be taken towards

ensuring registration of vital events – deaths and births.

A regular system of audit of maternal deaths will help in planning future strategies.

An important development in efforts to reduce maternal deaths has been the introduction of Misoprostol for prevention of PPH. Since a large number of maternal deaths are due to post partum haemorrhage, an effective strategy to prevent and treat PPH is expected to have significant impact on maternal mortality. Misoprostol is a safe, effective, affordable, and easy to administer medicine. WHO recommends its use in low

References

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resource settings. It has recently been included in the Government's Essential Medicine List (EML) so that it is easily available for a majority of women who need it. It has been estimated that if uterotonics including Misoprostol were made available at every birth over a period of 10 years, 41 million cases of PPH would be prevented and 1.4 million lives could be saved.⁵

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