Written evidence to the UK All Party Parliamentary Group on Population, Development and Reproductive Health Hearings into Maternal Morbidity submitted by the Royal College of Obstetricians and Gynaecologists International Office (RCOG IO)

1. Summary

The RCOG IO believes that access to comprehensive obstetric care should be the right of every pregnant woman. As a starting point, it is our firm belief that the continued reliance on untrained traditional birth attendants is unacceptable on humanitarian grounds and every effort should be made to support the training of skilled birth attendants in basic obstetric skills. We must ensure that the experience of childbirth is good for all mothers and they have access to safe services, regardless of their background or situation.

RCOG IO recommendations

A reduction in unsafe abortions around the world has been achieved primarily through legalisation. In many under-resourced countries, abortion is illegal, increasing the risk to women through unsafe procedures and practice. To help prevent unsafe terminations and unwanted pregnancies in these countries, the RCOG IO believes that comprehensive family planning strategies would reduce levels of unsafe abortion.

Obstetric fistula, secondary to obstructed labour, is common in countries with poor medical infrastructure. The use of the partogram and access to early caesarean section will reduce this complication. This condition is not seen in countries where good intrapartum care is available. The RCOG IO believes that development of comprehensive obstetric services, including prevention programmes, with good transport links could resolve this issue.

Eclampsia and pre-eclampsia can be reduced by antenatal and intrapartum surveillance and early transfer to a major hospital. The training and use of magnesium sulphate has been an important factor in successful treatment. Experience has shown that morbidity will be reduced by care in a tertiary centre if practical. The RCOG IO recommends that aggressive management be used to treat and reduce pre-eclampsia and eclampsia.

Postpartum haemorrhage (PPH) is the major avoidable cause of maternal death worldwide. The RCOG IO believes that good training and access to uterotonic drugs should reduce this problem significantly.

Most under-resourced countries have sophisticated protocols for managing mothers with HIV/AIDS. However, identification of such mothers still represents a challenge and antiretrovirals for mother and child are not yet widely available in many under-resourced countries. The RCOG IO believes that at this present time, alongside current programmes to improve and integrate service delivery during the antenatal, intrapartum and postpartum periods, there is need for further research into co-infections and HIV/AIDS.

Postnatal depression and psychiatric disease in the puerperium do not receive necessary medical focus in under-resourced countries. There is a need to raise awareness about postnatal depression amongst women in these countries. The RCOG IO recommends that funding should be provided and research
undertaken to address the issue, underpinned by an appropriate infrastructure with good support mechanisms.

It is worth noting that in South Africa, they have published confidential enquiries into maternal deaths (modeled on the UK system\(^1\)) since 1998. Three comprehensive reports have been produced so far and they are currently finalising the fourth report for 2005-2007. The data from these reports examine the causes of maternal death across the country and information gathered has helped doctors and healthcare professionals to identify issues and implement systems to lower mortality and morbidity. **With the appropriate funding to engage in long-term research, it is foreseeable that these reports are an invaluable resource to help reduce maternal morbidity.** Data from these reports can be used to develop processes, protocols and guidelines for the care of women.

What we need to do

Along with the maternal and perinatal death audit, in several countries the introduction of standards-based audit has been positively received and implementation has resulted in significant improvement in the quality and effectiveness of care. **The RCOG IO urges the development and introduction of audit structures to help improve clinical outcomes in each of its recommendations above.**

The RCOG IO would like to see continued emphasis placed on capacity building in under-resourced countries. This will be achieved through sustained training, clinical guideline development and easy access to comprehensive obstetric care, thereby taking a huge step towards helping these countries to reduce their levels of maternal morbidity. **Given the availability of expertise and its strong international networks, UK agencies should focus on forming working partnerships with health ministries and aid organisations in under-resourced to help develop their systems in medical education, training and standards.**

Finally, it is important to note that women should be encouraged, through community and/or women’s groups, to seek help when there are signs to do so. Grassroots educational programmes aimed at helping women (and their partners and relatives) help themselves will be the first step in reducing the delays which may cause maternal morbidity.

2. Where we are now

The Millennium Development Goals have focused attention on the prevention of maternal and neonatal death in under-resourced countries. With fresh commitment

from the G8 leaders and the United Nations to resolving MDG 4 and 5\textsuperscript{2}, expectations are high among providers that change will occur with financial investment in the provision of training and improved clinical facilities.

Currently over 529,000 women die globally from the complications of pregnancy and childbirth\textsuperscript{3}. Many more survive with long-term complications which impact profoundly on the quality of life for the mother. Most of these medical consequences are very traumatic for women but these are often avoidable and occur in communities with under-developed support structures.

Childbirth is unpredictable and UK data suggests that 20 – 30% of first time mothers will require more complex interventions to achieve a happy and fulfilling experience\textsuperscript{4}.

To follow is a list of common obstetric and gynecological issues which many under-resourced nations face. These have been gathered from comments provided by our international members\textsuperscript{5}. In some instances, examples of good practice are provided.

**Family planning and abortion services**

Current data suggest that 41% of pregnancies are unwanted\textsuperscript{6}, with a 22% termination rate worldwide\textsuperscript{7}. The availability of appropriate and accessible family planning services has led to lower rates of unwanted pregnancies\textsuperscript{8}. Examples are:

- In Cyprus good sex education and contraception has reduced unwanted pregnancy


\textsuperscript{3} Figure obtained from the World Health Organisation Q&A: Why do so many women still die in pregnancy or childbirth? Please see [http://www.who.int/features/qa/12/en/index.html](http://www.who.int/features/qa/12/en/index.html).


\textsuperscript{5} A list of contributors can be found in the appendix.


In Nepal, abortion was legalised in 2002. In 2004, comprehensive abortion care was introduced to prevent unsafe abortion.

South Africa has an extremely liberal policy on termination of pregnancy. This was enshrined by the first democratically elected Parliament in *The Choice of Termination of Pregnancy Act* (1996). The Act provides access for all women to abortions on request up to 12 weeks gestational age and in consultation with healthcare providers (medical and nursing) up to 20 weeks. Any termination of pregnancy thereafter has to be either for the benefit of the mother’s health or the fetus.

Despite these developments, provision of these services has been difficult. There have been numerous conscientious objections and challenges to the original legislation. The growing number of requests for abortion is because current contraceptive services have been deemed inadequate. However, South African doctors have reported that the number of unsafe abortions with multi-organ failure which was common before the introduction of the Act has fallen.

In Tanzania, Family Planning Services are provided through UMATI (Family Planning Association of Tanzania) supported by USAID through its many programmes. The organisation Engender Health are currently working on a campaign on the long-term methods of injectable progesterones and Implanon to prevent unwanted pregnancy and offers advice on child spacing. The postabortion care (PAC) project is supported by Engender Health and USAID. The treatment of unsafe and illegal abortions is offered at health centres and district hospitals. There are no services for abortions as the law in Tanzania does not allow the termination of unplanned/unwanted pregnancy.

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Women have access to a range of contraception in Sierra Leone. Marie Stopes International provides a good service there and provides women with information about contraception in the antenatal clinics. The problems experienced are cultural and economic. Outside Freetown, the country is mainly Muslim and male-dominated. To prevent daughters becoming pregnant outside marriage, daughters are married in their early teens and usually become pregnant before the pelvis fully developed. This has resulted in an increased incidence of obstructed labour and fistula in the female population.

**Prolonged obstructed labours – obstetric fistula**

It is estimated that there are about 2 million cases of untreated obstetric fistula worldwide, mainly in sub-Saharan Africa and Asia due to obstructed labour. The three delays in treatment – identification, transport and in instigating appropriate care; are the major contributors to the condition. The challenges facing the medical community in the provision of services are: access to professional skills, better transport links and the availability of special equipment such as the partogram. There
appears to be more funding available for fistula repair work than fistula prevention programmes.

- In Ethiopia the solution has been to raise awareness amongst women’s groups and community leaders at the grassroot levels, including religious leaders and farming associations. Partners, relatives and carers are urged to transport women to a health facility if the baby is not delivered within eight hours of labour commencing. However, this practice is now placing increased burden on the thinly available emergency obstetric care centres. For example, in one district, only one ambulance and driver are available. This service is used to transfer mothers to hospital, with no woman being more than two hours away from the centre (The current WHO/UNFPA recommendation is that one emergency obstetric unit is built for every 500,000 people). This is paid for by the community each year.

- In Sierra Leone, prolonged labour causes fistula and there is a shortage in those providing obstetric care. There are no plans to increase the numbers of midwives, and there is a reliance on auxiliary midwifery support who are based in peripheral health units.

- Prolonged labour with obstetric fistula has become less common in South Africa. The use of the partogram throughout the country has been encouraged. This is in contrast to previous times when there was recurrent outpatient referral of women with obstetric fistula.

- In Tanzania, guidelines exist at all levels on the management of labour. Use of the partogram is emphasised where deliveries are conducted and is a critical part of National Life Saving Skills and Emergency Obstetric Care training (EmOC). However, Tanzania still has a high fistula rate (2000/year) due to prolonged labour. Obstetric delays are often due to poor decision-making at community level and the poor infrastructure. The lack of skilled providers, equipment and supplies are central factors for the high fistula rates in Tanzania. The current national impetus is in improving health networks in the country by having a health centre at every administrative division. The aim is to reduce the delays which result in severe morbidity.

Whilst discussing fistula, it is also important to consider other physical consequences of childbirth such as urogenital prolapse. Such conditions have an impact on maternal morbidity and can cause long-term problems and misery for women if left untreated.

**Eclampsia/Pre-eclampsia**

These are avoidable causes of maternal death. Through the complications of cerebrovascular, cardiac, renal, haematological and hepatic complications, significant morbidity can occur. Both in rich and poor countries, resources are focused on early detection, stabilisation treatment and timely delivery, ideally within a unit experienced in the management of the condition. The widespread availability of magnesium sulfate has been a major contributor to improvements in the care of women.
In South Africa, eclampsia, pre-eclampsia and hypertension in pregnancy are common reasons for admission to tertiary obstetric units. Doctors treat large numbers of women with eclampsia. Patients who arrive within the tertiary unit at Groote Schuur Hospital with eclampsia have a very low mortality in comparison with those who are managed initially at primary and secondary level units.

In Uganda the problem is not well documented because many deliveries occur outside health institutions. Morbidity due to eclampsia has not been studied at all. Eclampsia is considered a seasonal problem particularly during the wet season. In the management of eclampsia, magnesium sulphate has been introduced and this has revolutionised the care and improved the maternal and fetal outcome. National policy allows midwives to administer the drugs.

In Tanzania, to prevent eclampsia, more than 98% of women visit the antenatal clinic at least once in their pregnancy. Prevention of eclampsia is through early detection during antenatal visits. However, there is inconsistent attendance of ANC by some women. The early detection of at risk factors in antenatal care is emphasised in the Road Map document.

Within India, the early detection and the universal use of magnesium sulphate are the mainstay of clinical policy.

**Postpartum Haemorrhage (PPH)**

Postpartum haemorrhage is a major cause of maternal death globally. With adequate training and resources, it should be preventable in most cases.

- In Uganda PPH contributes an estimated 25% of all the maternal deaths. Currently, a cluster randomised trial of misoprostol versus normal care on maternal health outcomes is being co-ordinated by Dr Andrew Weeks from Liverpool, with field work undertaken in Uganda.

Prevention strategies include:

Retraining midwives and other health professionals who conduct deliveries in active management of the third stage of labour (AMSTL).

Ensuring the use of oxytocins instead of ergometrine.

The registration of misoprostol for the prevention and treatment of PPH.

Guidelines have been drawn up by the Ministry of Health to ensure safety and rapid scaling-up in all health facilities. Strategies are being developed to care of women in cases where there is no skilled birth attendant.

Strategies are laid down to mobilise communities to participate and use available resources towards the reduction of maternal death with particular emphasis on improving referral and sustenance of human resource at
community level. Through their Road Map document, all sectors are partners in the efforts and have well defined roles.

- Within South Africa, PPH is perceived as the major preventable cause of maternal mortality. Effort is presently concentrated on better management and early recognition of the extent of obstetric haemorrhage. Professor Susan Fawcus is a national assessor for their Confidential Enquiry and heads the group reviewing the management. Deaths from haemorrhage occur in primary-level institutions in contrast to deaths from hypertensive disorders occurring mainly in the tertiary units. This suggests that haemorrhage is not recognised and appropriate intervention is delayed. In contrast, hypertensive patients are often referred to tertiary level care and given the benefit of interdisciplinary interaction.

- In Tanzania, PPH is the main cause of maternal mortality. Low haemoglobin levels significantly contribute to maternal death. The main cause is uterine atony after delivery. In the Road Map document, use of active management of third stage of labour (AMTSL) is emphasised using oxytoxin as an uterotonic of choice. National retraining of AMTSL is on-going through the National Life Saving Skills and EmOC training workshops. Lately, there have been efforts to introduce misoprostol at dispensaries, health centres, district, regional and referral hospitals for prevention and treatment of PPH. National guidelines on the use of misoprostol are in place and support the use of misoprotol. The Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) and the Ministry of Health and Social Welfare (MOHSW) with support of USA NGO Venture Strategies for Health and Development of California will soon roll out a national misoprostol training in all six zones of Tanzania.

- In Malaysia a training manual on the management of PPH by the National Technical Committee was published in 1998 and revised in 2005.

In discussing PPH, it is also important to consider the effects of chronic anaemia as this is long-term complication is a source of suffering for women with a PPH. Strategies should be developed to tackle the complications arising from PPH.

**Infections including HIV and AIDS**

There is evidence of good work in this area in many African states, with national plans for prevention, treatment and maternity care. This reflects the huge financial investment from foreign donors. HIV/AIDS also impact on complications arising from other infectious illnesses including TB, malaria and post-delivery sepsis.

- Within Uganda, HIV/AIDS remains at epidemic levels. Currently, the national prevalence stands at 7.1% in the general population and about 10% among pregnant women. HIV transmission is mainly heterosexual in Uganda, and it is believed that there are more women affected than men. HIV/AIDS among children below 15 years is usually the result of maternal-foetal transmission. This remains a major challenge since the country has not achieved universal screening of all pregnant women. An opt-out method for testing mothers is in
place. Testing is individualised. However, services are not universally available because of poor infrastructure.

Strategies have been put in place to try to avert the situation. These include: enhanced primary prevention; information, testing and counselling; couple/family counselling and testing; the promotion of condom use; preventing mother-to-child transmission (PMTCT) promotion; antiretroviral drug (ARV) administration to pregnant mothers and highly active antiretroviral therapy (HAART).

Infant feeding remains a problem. Culturally, it is a social stigma if a woman does not breastfeed her child. Other problematic factors include: poverty and inability to care for children adequately. However policy guidelines exist and women are being helped in feeding their children. These provide women with the option of exclusive breastfeeding until the infant is six months.

- In South Africa every province has its own service but there is national acceptance of the need for programmes to prevent mother-to-child transmission. HIV research on PMTCT and microbicide and dual therapy for PMTCT have been introduced. TB co-infection with HIV is a major issue and research on congenital TB is ongoing.

The prevalence of HIV in antenatal patients is assessed on an annual basis. In October each year samples from antenatal clinics around the country are sent for syphilis serology and anonymised and tested for HIV. The prevalence of HIV in all the provinces in South Africa is determined and this is utilised for health planning. The last survey suggested that 29.5% of all women attending antenatal clinics throughout South Africa were HIV positive, posing an enormous burden on clinical services. This figure does not reflect regional variations. The present policy is to offer every patient who presents for antenatal care in the public sector HIV screening. It is an opt-in rather than an opt-out service and most women elect to be tested in the certain knowledge that if they are tested the input into their care affects their baby’s survival. In the Western Cape, azidothymidine (AZT) is offered to all women who are HIV positive. Babies are treated with a combination of nevirapine and AZT long-term. Some women are offered HAART throughout their pregnancy.

- In Sierra Leone, patients attending antenatal clinics are checked for malaria and HIV, and provided with iron supplementation. There is a good system for malaria detection and treatment and HIV and TB testing and the provision of drugs. Improvements in provision has been noticed in the past years.

- In Tanzania, maternal infections, particularly complicated malaria and puerperal sepsis are major causes of maternal deaths. Puerperal sepsis a direct cause of maternal death. Of late, infections have gained momentum as major cause of maternal mortality due to HIV/AIDS complications. In HIV/AIDS patients, pneumonia and severe complicated malaria are common. Puerperal Sepsis and post-operative sepsis are also on the increase. No
critical studies have been done to document the magnitude of the burden of HIV/AIDS on maternal mortality in Tanzania but small scale studies are ongoing in the three teaching national referral hospitals. Malaria and anaemia are major indirect causes of maternal mortality in Tanzania. PMTCT services are offered countrywide with a national roadmap strategic plan. The coverage is still very low at 45%.

**Postnatal depression**

Poor mental health is considered an important cause of suffering for mothers in developing countries and there active groups working in several developing countries. Articles have been published in the *BMJ* and the *Lancet* providing an overview of the association of maternal mental illness and other maternal and child health outcomes in developing countries. Two trials published and to be published this year in the *Lancet* (Chile and Pakistan respectively) demonstrate the efficacy of low-cost approaches for the treatment of maternal depression. The Pakistani study shows that treating maternal depression has larger benefits for the child.

- In South Africa, postnatal depression receives inadequate attention because services are burdened by other demands on healthcare. However, in Cape Town, a group was established to review postnatal depression and is now affiliated with the Department of Psychiatry as well as the Department of Obstetrics and Gynaecology. There, an abbreviated form of the Edinburgh questionnaire is used to develop risk assessment for postnatal depression. Doctors have found that a large number of patients attending the clinics have been identified as affected or at risk. However, this facility lacks the infrastructure and funding to provide further care.

- In Tanzania, it is not given any attention because of the priority placed on other reproductive health issues and obstetric complications. The lack of facilities, equipment and supplies and low health budget contribute to non-existence of these services in Tanzania. There are few cases of puerperal psychosis and puerperal depression. Small-scale studies have been done mainly by medical residents.

RCOG IO, 26 September 2008

**APPENDIX**


The Royal College of Obstetricians and Gynaecologists (RCOG) is an international professional body with 11,000 members; the vast majority of whom work, train or are retired from the specialty. Half of its membership is based worldwide in 89 countries, while the other half are in the UK. It is involved in the postgraduate medical training, standards-setting and the development of evidence-based clinical guidelines which feed into national policy. The RCOG was formed in 1929 to address the high maternal death rate in the UK, which at that time, was 750 per 100,000 – the same as in parts of Africa, Eastern Europe and rural South-East Asia today.

The Liverpool School of Tropical Medicine (LSTM) has been a leading international institution for effective tropical research and capacity development in international health for over 100 years. It has a worldwide reputation for cross-disciplinary working and for establishing partnerships that lead to integration of research into policy and practice. The LSTM is a premier institution in the provision and promotion of high quality education and teaching in and for developing countries. The 200 academic research and support staff employed by LSTM have an impressive track record of managing research, funding and the logistics required to produce effective and timely outputs for complex multi partner international programmes. The Liverpool Associates in Tropical Health (LATH) is a not-for-profit subsidiary of LSTM and a dedicated technical assistance company providing quality programme management, consultancy and training services.

The RCOG International Office (RCOG IO) was formed in 2006 between the RCOG LSTM and LATH. Its aims are to help reduce the burden of maternal morbidity and mortality in under-resourced countries through the sharing of knowledge and expertise with local health professionals.

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