Technical Working Group 4: Maternal Health (MDG #5)

Chair: Deputy Minister of Public Health

Chair: Now we are discussing two indicators: Maternal mortality ratio (by number of live births) and proportion of births attended by skilled personnel. There are lots of synergies between MMR, IMR and other health issues.

Dr Pinney: 2005 Report of the State of the World's Children modeled 1900 maternal deaths per 100,000. We also have empirical data from a 2002 CDC study in 4 districts of 4 provinces. Chosen to represent diversity of Afghanistan – urban, rural/peri-urban, rural and isolated rural. In one district in Badakshan, a rate of 6507 deaths per 100,000 was the highest recorded in the world. Half of all women die due to pregnancy related causes in Afghanistan. The CDC study then attempted to generate a national estimate using similarity of population estimate, ie, those four figures were assigned to provinces with similar environments. Came up with 1600 (excluding Badakshan figure) and 2200 including it. The weighting has huge opportunities for bias to creep in. Despite its shortcomings, it is the most rigorous study.

UN estimate in 2000 was 1900 per 100,000.
UNFPA estimate of 1700 is comparable with S Sudan.
UNICEF BE = 1600.
MoPH = 1600.

Linda, UNICEF: UNICEF CDC study 2002 gave the 1600, being conservative and excluding Badakshan. However, there is no reason to think that the 6507 is inaccurate for the district in which it was done, so many have asked that it be included. If we accept 1600 as the baseline, the goal is 400, if we accept 2200 then the goal is 650. May set ourselves a false goal by excluding the Badakshan data from the national estimate for the baseline. Classified the districts into types of population density and then applied the closest numbers from the study. The study was a one-off, but plan to repeat in 2008 to measure the UNCT joint programme target of reduction in MMR by 25% by 2008. 5-6 years might not show much of a change, as pregnancy is a year. We plan to do the same sites and then to expand also. Definition of MM: death within a year of pregnancy outcome, either from direct causes such as haemorrhage, and eclampsia, or indirect causes such as surgical interventions such as C-sections.

Chair: what are the key causes of MM in Afghanistan?

MOWA: lack of attention and care before and after delivery. Lack of access to skilled health personnel, facilities. Family violence also has a role, economic factors, cultural factors, customs all lead to maternal mortality. They cannot enjoy their right to health

Chair: What are the causes and how is it measured? We have agreed to the benchmark of 1600?

Swiss Development Committee: also influenced by other poverty and cultural factors, not just medical. Many of the deaths reported were preventable. Women are not the decision makers, they are powerless. We need to work with communities to change their attitudes and perceptions.

Where they do have access, they don't make use of it for other reasons. The target is very ambitious, but maybe we need it to mobilise resources.

Dr Sinha: The next reliable data comes out in 08/09. So all policy and programming will be done on this basis until then. We are making a huge guess here, so what happens if it is not reliable. Any proxies? Any opportunity to corroborate that at an early stage?

Dr Pinney: Afghanistan is one of the only countries where there are more men than women (despite the war) and where men live longer than women, and where there are few women over 65.

Dr Farhadi: Is it possible that there is just under-reporting?

Dr Pinney: yes, in the household listing survey, but the age stats are very compelling.

Chair: yes, this has been bourne out in our own studies. Mental problems (est 50-70% of pop) are contributing to all of this.

WHO: There is a need for further research. There are more men than women here. If we talk about social factors - haemorrage, induced labour. These are the direct causes. Also the indirect - TB kills more women than men in A. Early marriage is another huge factor - marriage at 14 is not uncommon. The teenager is thus exposed to high risks and even death. This practice increased in the war years. Malnutrition - a social issue- as women eat less. Domestic violence also needs to be addressed. Education and literacy also help to improve. The war took the lives of the men, but why are women dying?

Farhadi: we claim 1m dead in the Soviet invasion. Now we see the statistics on maternal mortality and child mortality. What would have happened without the conflict? We're doing quite well if the population is now 28m?

Dr Pinney: we are talking about relative death rates. Usually men die younger and more of them are born in the first place.

Dr Sinha: Population growth rate is 2% and typical for the region.

Katja, MOPH: the target is 75% reduction. It is extremely ambitious. Even 50% is very challenging. Will need some progress indicators. We must be consistent with this morning and reduce the target.

Chair: please remember that this is one of the top priorities of the Government and also many of our partners.

WHO: the 1600 is our best estimate. After 15 years, we have to compare to where we started. We can model the figures every two years from the 1900, but we have to repeat the 1600 survey to measure progress as there is the same methodology is an issue.

Dr Sinha: There might be an option to just look at the end target. I am hesitant about the 1600 data as a national level. Where do we expect to be in 2015? 800, 600 or 1000.

Dr Pinney: as with child mortality, measles vaccine is the major instrument to reduce it. In the MMR it is the skilled professionals. In Linda's paper, we see high levels of obstructed labour in Badakshan and presumably poor access to skilled personnel. MICS shows us that 14% of last births were attended. Just 7% in the rural areas, 35% in the urban. Big regional variation. Compare with 5% in rural south Sudan. Good comparator to the 1600. Seems to be linked. MICS gave a similar figure. Is this the main instrument for combatting MM - and what is our plan to deliver it?

Linda, UNICEF: Process indicators - number of attended births, access to family planning. These are easier to measure but aim for both. I don't think that 1600 is very controversial - it is consistent with WHO modelling and the range 1600-2200 (1.6%-2.2% of women will die in childbirth) and the variation is fairly small. A bunch of consistent findings. If we take the 1600, note that this is the lower range, and if we set our targets accordingly, this is EVEN more challenging. A 75% reduction. And here especially, this is a challenge as all the social factors come in to it.

Director of Grant Management at MoPH: Too challenging, even in stable LDCs. Afghanistan has further to go.

WHO: It is quite obvious that we don't have the specific figures.

Dr Pinney: can we quote a range of where we are and a range of where we want to be?

Chair: I know this is a hard issue to change. Even if we achieve it, the results take more time to show. I am optimistic - we have the cooperation of the whole world. Everyone knows how desperate the situation is for mothers and children here. Let's aim high. 50% by 2015 and 75% by 2020. We could do better than our neighbours because of our determination. I think we can achieve 6-700 in ten years and then it will level out. That's why I want to see the ANDS.

SDC: We need a good strategy. Overcoming issues such as cultural decision making and trained female workers. Transportation should be dealt with first. Don't see harmony between HMIS (?) and obstetrics surveys.

UNICEF: I agree that 50% by 2015, and 2/3 for 2020 or 75% for 2020? Andrew's suggestion of a range might be prudent. If we take 1600, a reduction of 25% by 2008, UNCT goal = 1200 and then 2015 would be 800. This is both challenging and optimistic.

Farhadi: The expectations of our people weigh heavily upon us. How can we bridge the gap between expectations and delivery? This is a crisis, according to the statistics cited by Andrew. We continue to make the case that Afghanistan is a special case. Yes, there are obstacles but we have to make significant changes to the lives of ordinary Afghans, even if it means that we have to work 16-18 hours a day. This crisis needs to be addressed in the MDGs. This has to go to Parliament.

Linda, UNICEF: Just an observation. We talked about the fact that we would have an early high impact on the child mortality, but for maternal we could expect to see a different pattern. A slow a start as we are talking about LT inputs such as training attendants and building roads.

Chair: we hope to borrow skilled labour from our neighbours initially.

Dr Pinney: suggestion slide - a range at 50% for 2015 and 75% for 2020.

Linda, and WHO: I agree with these optimistic but reasonable goals.

USAID: It would be much better to go for a single figure.

Dr Pinney: I think we need to insure ourselves against the bad data.

Farhadi: Does the range have to be so wide?

Andrew: the range is based on the original measurement. It's based on primary data which is unusually good.

Chair: We also have a range for the IMR and for the U5 MR. But we are presenting single figure target.

WHO: Difficult politically to present a range. Also the 1600 has been used so much over the past few years.

Chair: MOPH and MOWA will use this range for the planning purposes, but perhaps we should have a single target for this report/purpose.

Dr Sinha: NDS needs to be much more specific.

USAID: We'll use single figures for our projects.

WHO: people are forgetting that 1600 excludes Badakshan as an outlier.

Linda, UNICEF: Both arguments have positive aspects. But we want to use the strongest data that we have which is the range. We are not convinced that we can leave out the Badakshan data. 1600 could be a big underestimation for Afghanistan. In future documents we should talk about the higher level of the range.

Chair: MMR is per 100,000 live births. Depends on the overall size of population. I agree it is feasible to have the 6507 in Badakshan, as other health indicators are also low. But maybe Badakshan is a small population?

Linda, UNICEF: It is a very large sample size. This figure translates to 6.5% of women dying from childbirth related issues. This is feasible.

Dr Sinha: Is Badakshan an outlier or are there other places similarly remote in Afghanistan?

Farhadi: What will be our policies? They will be different for 1600 and for 2200.

Dr Pinney: Badakshan is not the worst in terms of food security - Ghor is worse. So I would put money on MMR also being high there. There are other remote areas that have very bad indicators of poverty and food security.

Dr Sinha: I am hearing that people want a single figure. Badakshan could be included on good grounds, so we could move from the 1600 to the 2200.

Chair: We are saying 50% but not 50% of what. We can take the 1600 for now and then revise it when more info comes to light. If you agree we will take the 1600 as the figure, understanding that we use the range for planning, and that other data may come to light later. By 2020 we shoot for the 75% reduction and by 2015, 50%.

?? Border and Tribal Affairs: Badakshan is representative of other areas, very mountainous and very remote. The case in other provinces.

Linda, UNICEF: It is consistent with what else has been reported. But I would like the document to discuss the range, and for people to understand that Badakshan was excluded. This is a data driven understanding of the situation.

Chair: how will we be getting the data in the future?
We have to discuss the second indicator - the proportion of births attended by the skilled attendants.

Dr Sinha: this indicator is linked to the MMR - close proxy I assume.

Katja, MoPH: MoPH are looking at midwives and 90% of existing midwives are not passing the exams. There is also a very low utilisation of facilities. The women do not have the confidence to go. In 2002 only 40% of health facilities had qualified female staff.

Linda, UNICEF: Is there a goal for the number of skilled birth attended?

WHO: the UN working group has set a target of 30% for 2008.

Dr Sinha: Pakistan is 33%, Sudan is 6%.

Linda: 65% of the deaths, in our survey were during birth, so birth attendance target might be derived from this.

Dr Sinha: to 30% by 2008, and then 50% in 2015

WHO: maybe faster - 50% in 2010 and 60% in 2015.

Chair: I like that link between our MMR target and the attendance target. Would be good if we could do that calculation.

Linda, UNICEF: minimum of 50% by 2015, in combination with birth spacing and transport etc.

Dr Pinney: 42 births per 1,000 population. 1 million births annually. We want half to be attended by a midwife, so per month we need to attend 42,000 so if each midwife can attend 20 births a month. Need 20,000? 125 midwives just graduated and we can expect 300 per year, so 7 years needed to provide 21,000. Assumes distribution. It will take 10 years to get 50% of births attended by a skilled midwife.

Chair: Thanks this has policy implications. This is indeed an ambitious target. This is the kind of analysis that we need. We will scale up the programme of training for the midwives and bring them across the border from our neighbouring countries

MOWA: MMR is a function of the lack of midwives but also about the social and cultural issues, the fact that women cannot see the male doctors.

USAID: More women doctors are also graduating now, so there will be more women attending births.

Dr Pinney: But midwives rather than the doctors are at the front line in rural areas.

USAID: The roads and telephones are key in this regard. A WHO study tested what factors are most responsible for poor health care. Financial, physical and social access, was found to be key.

Linda, UNICEF: Do we want to set a target for 2020? We need to finesse the target a little. We made a huge assumption of 20 attendances per month. We will work on this more.

Chair: We have agreed on the 50% by 2015 and 75% by 2020. What is the source of data to track future progress?

Dr Sinha: Will we continue to monitor the MMR in the same way? Or other sources?

WHO: MICS started in 1997. Not always reliable. We believe that most of the health services are provided by internationals here, but now we are building the capacity of the Govt and the ownership of MICS now has to be with the Govt.

SDC: HMIES can provide a lot of this info. MMR will be reported routinely by the obstetrics activity report. Piloted in 5 centres of excellence and has been revised accordingly. But many women die at home so the data at the clinic level is inadequate so we need the survey data also.

Linda, UNICEF: What plan does the Govt have to measure births and deaths in the community?

CSO: Role of the Ministry of Interiror to record births and deaths registration.

Chair: We have run some pilot studies. You can involve the Mullah in a community, as he is involved in the associated rites such as burial. 70-80% of births reported are male - do special prayers and circumcision etc, so have to get other sources of information on the female births - the

village barber (he does the circumcision and also cooks food for the celebrations). The barber's wife is the critical one for the data collection.

SDC: CW reporting is also an option.

Chair: Agree on a good number of sentinel sites for the recording of average areas. This will be discussed under the ANDS.

Dr Pinney: NRVA 2005 is collecting urban and rural, samples on the attended births. 32,000 sample.

WHO: The data we have is that only 3% of births are in the facilities. So how can we monitor in the clinics - we'll miss everyone. The NGOs have health workers responsible for 1,-2,000 people. We can use them, as well as the Mullahs etc.

Chair: By sentinal site, I don't mean the facility I just mean the village.

Linda, UNICEF: Yes, regular monitoring is very important. I'd support the building of the capacity of the Govt to survey the vital statistics, village surveillance etc

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