



Maternal Mortality Estimates: What do they tell us?

25 May 2010
15:00-17:00
SIT Study Abroad

15:00 Welcome and Introduction **Aagje Papinau Salm - Chair Share-Net**

Aagje welcomed everybody to the meeting and shortly introduced the speakers.

The meeting is organized around the new maternal mortality figures recently published in the Lancet (Hogan et al., 2010) estimated by the Institute for Health Metrics and Evaluation (IHME). Several speakers are invited to elucidate how these new estimates have been produced and how to interpret them.

15:10 Estimating maternal mortality - a discussion on methodologies **Lale Say - WHO, Medical Officer for Monitoring and Evaluation, Department of Reproductive Health and Research**

Mrs Say gave a presentation clarifying the existing differences in maternal mortality estimates. As she is involved with the inter-agency (WHO, UNICEF, World Bank and UNFPA) estimates she can very well reflect on the methodologies used and explain their relation to the numbers. Here, some highlights from the presentation are presented. The whole presentation can be found [here](#).

First of all it should be noted that maternal mortality is one of the most difficult indicators to measure reliably, as it is complex to correctly assess the number of deaths of women of reproductive age, and to correctly classify these. Main sources for maternal mortality data are: vital registration systems (VRS), Reproductive Age Mortality Surveys (RAMORS), census data based on special questions regarding adult and pregnancy-related mortality, DHS surveys based on the direct sisterhood method, sample registration data (data from epidemiological surveillance sites or surveys covering part of the population) and the indirect sisterhood data from (older) DHS, MICS or some censuses.

Unfortunately none of these sources are at face value, as there is substantial misclassification (there is a thin line between maternal mortality and pregnancy-related mortality) and underreporting. Also generalization of i.e. epidemiological surveillance site may be problematic.

The inter-agency estimates are based on an approach that encompasses different sources of data. Data from the direct sisterhood method are 16.3% of the total data sources from the inter-agency estimates, IHME estimates had 7.7% DHS (sisterhood) data of overall data points. DHS estimates are usually higher than the vital registration data, which might partly explain the differences between the two estimates. The IHME estimates are based predominantly on vital registration data for some countries with low coverage (10% or more of the overall number of deaths are under-registered) of death registration without controlling for the type of data used

Besides, some other methodological issues were noted that could explain the differences in the estimates and trends: the statistical model used by IHME does not use any adjustment factor/control variables for individual country estimates. Trends over time may be biased due to an uneven spread of sisterhood data points compared to the vital registration data points - more sisterhood data points in the earlier time periods, more vital registration data points in the later time periods.

When comparing the estimates though, it can be noted that the IHME estimates are within the inter-agency variations. Moreover, the estimated trends of maternal mortality are not very much different.

Dr Say concludes with emphasizing that the discussions around different estimates and modelling strategies should not deflect from the urgent actions required to address maternal mortality.

Maternal mortality remains unacceptably high and as long as women do not have access to family planning and maternity care, and are giving birth at home, without skilled assistance, they will face an increased risk of dying.

15:45 Connections Between the HIV Epidemic & Maternal Mortality

Odette Salden – STOP AIDS NOW!, Policy Officer

Odette Salden provides a presentation on how HIV/AIDS relates to maternal health, and thus maternal mortality, and how the implications of this relation can be addressed in an integrated approach to reduce maternal mortality, promote SRH and preventing HIV.

From the article by IHME on maternal mortality (Hogan et al., 2010) it appears that nearly one out of every five maternal deaths - a total of 61,400 in 2008 - can be linked to HIV. Salden reflects briefly on the direct and indirect relation of the HIV/AIDS epidemic on maternal mortality. Given this relationship, it is inevitable to develop and implement comprehensive, rather than isolated, policies and interventions. Since some years it has been recognized that SRH services form a critical component of effective HIV/AIDS care. Support for this integration comes from both the human rights (to counter discourage of reproduction and encouraging contraceptive use among HIV-infected women) as well as the service delivery perspective. Bi-directional linkages between SRH and HIV-related policies and programmes can lead to a number of important individual, public health and socioeconomic benefits, such as: improved access to and uptake of key HIV and SRH services, better access of people living with HIV (PLHIV) to SRH services tailored to their needs, reduction in HIV-related stigma and discrimination and improved coverage of underserved/vulnerable/key populations.

Although this is a step forward maternal health is still not explicitly enough integrated within SRH and HIV/AIDS policies and interventions and vice versa, particularly when it comes to addressing maternal mortality and morbidity within HIV programmes. Moreover, there are still some identified gaps in the development and implementation of SRH and HIV/AIDS policies and programmes alone. What is needed to come to an integrated approach to reduce maternal mortality, promote SRH and preventing HIV is some overarching themes to work on, such as: promoting human rights (SRR) and reducing stigma & discrimination, improving services, and changing policies. Also, Ms Salden comes with propositions on how to integrate services (a.o. integration of ARV treatment in SRH services) and underlines what is needed on the policy and management level to bring about such changes in service delivery.

To view the presentation, please [click here](#).

16:05 New Maternal Mortality Figures: some views from the Dutch SRGR policy perspective. "How to read good news".

Lily Talapessy – Ministry of Foreign Affairs, Policy coordinating officer SRHR, Health and Aids Division, Social Development Department

Mrs Talapessy, working for the Ministry of Foreign Affairs, gives a presentation setting out how the Ministry handled the publication of the new IHME estimates on maternal mortality and how these might implicate Dutch policy in this field.

First of all, Mrs Talapessy, quickly summarizes Dutch policy on SRHR and HIV/AIDS. SRHR and the fight against HIV/AIDS have been prioritized in Dutch development cooperation policy for the years 2007-2011. Besides, former Minister Bert Koenders for Development Cooperation, increased the Ministry's attention for safe motherhood during the last couple of years. The policy emphasizes the following five aspects:

1. Integrated approach towards SRHR, HIV/AIDS and maternal health;
2. Human rights as a firm starting point.
3. Integrated approach to MDGs in general, with emphasis on MDG5a and 5b
4. Key words: prevention, family planning, information, access and care. Abortion, where legal, certainly is part of this policy, as is post abortion care.
5. Focus on women, girls and adolescents;
6. Focus on vulnerable, marginalized groups, such as MSM, sex workers and drug users.

Policy is based, amongst others, on the inter-agency estimates of maternal mortality. Therefore, the recently published article with new estimates by IHME is highly relevant to the Ministry. In reaction to the article's release the Health and Aids Division of the Ministry alerts embassies and shares the article with them. The Health Department then writes a summary policy note as information for the Ministry and embassies, as well as a more detailed policy note for the Health Specialists at embassies in Partner countries. The latter is a policy steer, as well as an invitation to discussion between the Health Specialists and the Division..

The Ministry welcomes the new numbers and regards lower estimates of maternal mortality as good news. However, the reduction in maternal mortality still does not go fast enough. The IHME, like the inter-agency, presented *estimates*. More reliable data and analysis is needed. Mrs Talapessy too asked to focus discussion on the story behind the figures instead of focusing only on the different methodology – moreover because the upcoming inter-agency figures may show maternal mortality trends comparable to the IHME results .

Therefore the Ministry concluded the following:

- Constructive communication is key. IHME's new estimates stimulating discussion on policies and interventions in the field of maternal health, SRHR and HIV/AIDS is helpful. Transparency about data and analysis used is needed;
- Family planning is essential to improving the health of women and mothers, including in preventing maternal mortality. Address unmet need for family planning, with special attention for young people.
- An integrated HIV/AIDS, SRHR and maternal health approach is needed. MDGs are interlinked, not isolated (so no 'competition' between MDGs!);
- Education does remain a key prerequisite to development;
- This article also illustrates that economic and social sectors are interlinked.

In conclusion, the IHME findings confirm the relevance of the Dutch SRHR policy.

Discussion

- Maternal mortality includes mortality from all pregnancies – including those that end in induced abortion. However, IHME did not examine possible differences in rates of decline by type of pregnancy outcome. It has been assumed that abortion mortality declined, yet that could not be confirmed by the IHME study.
 - Abortion related causes are missing, as measuring this relies heavily on vital registration, which clearly poses difficulties.
 - The IHME is not a study of determinants of maternal mortality. That could be one of the reasons why maternal mortality was not further categorized.
 - This issue probably created an underestimation in maternal deaths in Brazil and Jamaica. IHME maternal mortality rate (MMR) was 55 and 34 respectively, while official national estimates are 74 and 85.
- 'What do we do with good news'? It is good to hear that, if the estimates are correct, maternal mortality figures are much lower than generally conceived and the trend is downwards, but it would be helpful to learn more about the policies and interventions in those countries with low, or decreased, estimates.
 - We should try to prevent that policy will now shift from an integrated approach towards a focused policy on HIV/AIDS only. (This has been proposed on a blog on the internet.)
 - Good news should lead to action; too positive estimates can lead to 'leaning back'.
 - More indepth analysis of the policies and interventions leading to low maternal death would be helpful to stimulate governments to keep attention to maternal health
 - Research should be used for political action, but only if you are sure about the figures.
 - Good news should not be seen as bad news for your funds. We should emphasize that maternal mortality is still unacceptable high and that decline is slow.
 - Secretary General of the UN Ban-Ki Moon, recently announced new maternal health initiative. On higher political levels, maternal health remains on the agenda.
- Are there more sessions like this around the world to discuss the impact of the figures?

- Researchers from the IHME and the inter-agency will come together at Women Deliver.
- It is very helpful to have these discussions. It is good to see that countries are very responsive too. They have many questions on the numbers (and their differences) circulating around. Countries do not automatically accept the new numbers, as they might not always be consistent with national official numbers (i.e. Jamaica and Brazil).
- To what extent is it possible to replicate the calculations at country level?
 - The calculations and analyses is very complex. Even for the inter-agency it is not easy to replicate. This is a great drawback of the IHME study.
- In Afghanistan there are excellent strategies to measure maternal mortality. Latest numbers came out in 2002. At the moment local researchers and WHO staff are involved in the set up of a new estimation. How will these numbers be integrated in the new inter-agency numbers that will be released soon?
 - The new estimates will probably be included in the next estimates only. For the upcoming estimates, 2002 numbers will be used.
- What can we do to keep the Netherlands an important player in the field of SRHR?
 - It would be helpful if Dutch institutes would express their commitment to work on an integrated approach to HIV/AIDS, SRHR and maternal health to for example the WHO.