EDITORIAL

Need to Intensify Safe Motherhood Interventions in Africa

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Recent evidence suggests a trend towards an increasing rate of maternal mortality throughout much of sub-Saharan Africa. In a country such as Nigeria, maternal mortality estimates climbed from 600 per 100,000 in 1987 at the launching of the international Safe Motherhood Initiative to 1000 per 100,000 in 2000; and now, it is nearly 1,500 per 100,000 live births. Indeed, recent data published by UNFPA/UNICEF indicate that Nigeria now has the second highest rate of maternal mortality in the developing world. Similarly high rates of maternal mortality are being reported from several East and West African countries including Ethiopia, Mozambique, Tanzania, Zimbabwe, Ghana, Liberia and Sierra Leone.

Several factors account for this unsatisfactory state of affairs. The first is the declining priority accorded to the prevention of maternal mortality as a component of reproductive health. Since it became known that HIV/AIDS is principally an African epidemic, programmatic emphasis has tended to shift from other reproductive health issues to HIV/AIDS. Many African governments, while increasingly taking the HIV/AIDS challenge more seriously, have not shown commensurate commitment to other reproductive health problems especially maternal morbidity and mortality. Furthermore, throughout sub-Saharan Africa, international donor funding has increased for HIV, while it has decreased significantly for issues surrounding maternal mortality reduction.

The second problem is the fact that maternal mortality is not quite the same as HIV/AIDS. Both are no doubt driven by poverty and declining national economies. However, while HIV/AIDS may respond to short-term interventions at the individual and household levels, maternal mortality requires the integrated improved performance of all sectors of the national economy over a longer period of time. Indeed, it is now understood that maternal mortality is associated with complex infrastructural, cultural, socio-economic and political issues, which need to be addressed simultaneously before a decline in rates can be achieved. Thus, interventions must include true multi-sectoral designs and considerations before they can reach the "heart of the matter" in addressing maternal mortality in Africa in a realistic fashion. To date, not many African countries understand this peculiarity of maternal mortality, and not many have taken steps to re-direct their efforts appropriately.

At the programmatic level, the prevention of maternal mortality depends on the three components of primary, secondary and tertiary prevention. Unfortunately, all three levels of prevention are very poorly developed in many parts of Africa. Primary prevention, the reductions in untimed and unwanted

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pregnancies that place women at risk of death, is not working well in many parts of Africa. African countries, especially those with high rates of maternal mortality, have some of the lowest contraceptive prevalence rates in the developing world. Indeed, an inverse association currently exists between high rates of maternal mortality and contraceptive prevalence rates in Africa, and there is a large unmet need for contraception in countries with high and rising rates of maternal mortality. Unless efforts are concentrated on increasing contraceptive use by vulnerable women, especially adolescents and highly parous women, it would be difficult to achieve significant reductions in maternal mortality in the foreseeable future.

Secondary prevention, the judicious use of quality antenatal care or the termination of an unwanted pregnancy, also poses significant challenge in many parts of sub-Saharan Africa. Antenatal coverage range from as low as 40% in countries such as Mali and Nigeria to as high as 80% in Zimbabwe and South Africa. Even in countries with high antenatal coverage, the quality of services is often less than optimal, and there is currently no evidence that antenatal care in itself improves many of the proximate medical and social factors that lead to maternal mortality in Africa.

Termination of pregnancy is legally restricted in many parts of Africa and, therefore, women often have limited access to safe abortion services. Consequently, unsafe abortion is presently one of the leading causes of maternal mortality in many African countries. The most badly affected countries are Ethiopia, Kenya, Mozambique and Nigeria, where abortion constitutes between 20 and 50% of all cases of maternal deaths. It is clear that unless measures are taken to address the problem of unsafe abortion in Africa, maternal mortality would not be expected to fall anytime in the near future.

There is now a growing consensus that tertiary prevention, the prompt treatment of complications that lead to maternal mortality, holds the key to reducing maternal mortality in developing countries.[1] However, if tertiary prevention is to be effective, pregnant women must be able to reach health facilities on time when there are complications, and the facilities themselves must be fully equipped to manage pregnancy-related complications. Here again, there are problems in many African countries. Today, it is well-known that a large proportion of pregnant women in several African countries are not attended to in labour by a skilled birth attendant, that many women fail to reach an obstetric facility in time when they experience complications, and that there are institutional delays that prevent the prompt management of complications that lead to mortality.

This issue of the *African Journal of Reproductive Health* carries nine articles that are related to the prevention of maternal mortality in various parts of Africa. The paper on the estimation of maternal mortality in Western Tanzania by Mbaruku and his colleagues[2] describes the use of a simple method – the sisterhood method – to determine the true community incidence of maternal mortality. Throughout Africa, maternal mortality statistics are often inaccurate, derived as they often are from hospital data which do not fully reflect the true state of affairs. Community data such as those based on the sisterhood method are much more representative. The verbal autopsy method is another good way to determine the true community causes of maternal mortality; however, this has also been poorly used in Africa. Community-based studies of this nature are to be encouraged from different parts of Africa, as they hold the key to our improved understanding of the true rates and determinants of maternal mortality. Indeed, as we increasingly undertake community-based interventions that seek to promote safe motherhood, these kinds of data are necessary to monitor our efforts over time.

Three articles from Nigeria[3,4,5] show that abortion is still a significant problem in the country. They all call for a realistic approach in dealing with the problem, in particular the training of health practitioners in efforts to reduce the rate of maternal mortality in the country. Such trainings are based on the principle that when the skills of health providers are improved in delivering emergency obstetric services, they can use limited resources to deal with abortion-related complications and reduce the likelihood of maternal deaths.

The paper on the utilisation of antenatal services in Equatorial Guinea by Jimoh[6] and that of antenatal screening for hypertension in rural Tanzania[7] both

underscore the point on the limitations of antenatal care as a secondary prevention strategy for reducing maternal mortality in Africa. In particular, the papers justify the need for backing up antenatal services with improvement of women's access to safe delivery places and emergency obstetric services as the linchpins of safe motherhood in Africa.

Thus, the real question for maternal mortality reduction in Africa is: how can we increase women's access to skilled birth attendance and emergency obstetrics services in Africa? We believe that countries and communities that answer this question satisfactorily stand a better chance of experiencing marked reductions in maternal mortality rates. Significant progress can be made when there is proactive and strong political leadership, when various indices of social and economic development are addressed within countries, when the several inequities that hinder women's social development are minimised, and when specific efforts are made to improve the deteriorating health infrastructure in many countries in the continent. Without these, we should not expect significant improvements in maternal mortality statistics in Africa anytime soon. Indeed, we hold the view that the true test of the economic progress in any African country in the coming years will be the extent to which it relieves the factors that lead to maternal mortality in its component constituencies.

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