

Update Health Policy Decision Making In Safe Motherhood Regional Issue

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Abstract

More than a half million women die every year because of complications related to pregnancy and child birth. Nearly all these deaths take place in developing countries. The disparity between maternal death rates in developing and developed countries is greater than for any other common category of death. Poor maternal health during pregnancy is directly linked to poor health in the infant. Therefore, a mother's health and survival continues to be critically important throughout a child's life. Pregnant women and children suffer first and most under poor socioeconomic conditions. To reduce maternal and morbidity in half by the 2000, the safe motherhood initiative was launched. The success of safe motherhood initiative depends on the active participation of a wide range of individuals and organizations who can contribute ideas, skills, and funds, because the problem stems not only from inadequate health services, but mostly also from the social, cultural, and economic environment in which women live. Health policy decision making in safe motherhood at least should be based on the assessment of Maternal Health situation and health services and the assessment of socio-cultural aspects of safe motherhood of each region.

Keywords : Maternal health, infant health and child survival, health policy in safe motherhood

I. INTRODUCTION

Hildbearing may be one of the most special events in women's life, but it may also be one of the most dangerous. Each year 500,000 women die of pregnancy-related causes where nearly all these deaths are in up to 100 times higher than that a woman in a developed country. In fact, more than a quarter are maternal deaths. Therefore, maternal deaths is considered to be the health indicator which shows the greatest differential between developing and industrialized countries (Mahler, 2017).

The majority of maternal deaths occur around the time of delivery, and much effort has gone into identifying and providing effective and appropriate delivery care to prevent these deaths (Rooney, 2012). The chain of factors that underlies poor maternal health is deeply rooted in the adverse socio-economic and legal environment in which women live. Bathia (2013) on his study on levels and causes of maternal mortality in Southern India demonstrated that approximately one-half of maternal deaths occurred at home or on the way to hospital and many of these deaths were actually preventable with regard to demographic, social, and behavioral factors. The problems are fundamental, the solutions require interlinked action, and the strategies must be long term.

The first International Conference on Safe Motherhood held in Nairobi in 1987, succeeded in creating an awareness of the magnitude of the problem and encouraging governments, particularly in the developing countries, to give high priority to the Safe Motherhood Initiative was launched to reduce a terrible human toll by improving socio-economic and political status for girls and women, making appropriate family planning for all, preparing high quality pre-natal and delivery care for all women and facilitating skilled obstetrics care for high-risk and emergency.

II. THE IMPORTANT ROLE OF MOTHER

As mothers, educators, and producers of goods, women play a pivotal role in common struggle for development. Therefore, a woman's death or poor health also has serious consequences for the health and well-being of her family, community and nation. Each year, seven million infants die within six weeks of birth because their mothers received inappropriate prenatal and delivery care. Poor maternal health during pregnancy is directly linked to poor health in the infant; and when a mother dies during childbirth, her infant is almost certainly to die as well (Tinker & Post, 2010). A mother's health and survival continues to be critically important throughout a child's life. Many of the conditions that cause death and disability in mothers are, therefore, directly linked to child mortality and morbidity as well. These deaths, however, are rooted in traditional customs and practices which give preferential treatment to boys in nutrition, education, and access to health care. Girls are married off at early age, and are expected to bear children under ten years of age-particularly girls children-were up to four times more likely to die if they had lost their mothers. and not as an independent document. Please do not revise any of the current designations.

III. PROBLEMS IN SAFE MOTHERHOOD

The biggest problem of safe motherhood in the developing world is under reporting and misclassification of maternal death that blur the picture of maternal mortality. Vital statistics when exist-sometimes grossly under estimate maternal death. The exact national figure is not always known because maternal mortality and morbidity data are scarce or cover only a limited area. According to WHO (2010) globally the highest level of maternal mortality is 1,000 live births and the lowest level is 5-10. The general maternal and perinatal mortality figures are not comparable due to the use of different definitions, and according to experienced researchers, under reporting may reach as high as 50% (Sastrawinata, 1987). The general factors associated with such high rates of maternal deaths have been identified as: (1) Malnutrition and anemia are common afflictions for women; (2) Health facilities are often inaccessible-financially, geographically, or culturally-or of poor quality; (3) Too many deliveries take place without assistance of a trained attendant; (4) Women also lack access to antenatal services and post-natal care that could save their lives; (5) Unsafe practices are common, and trained medical help is often sought only after life-threatening complications arise; (6) Communications, information, and transport systems are poorly

developed, making it difficult to link a dying woman with life-saving medical services.

The low priority accorded to maternal health is conceptualized by Graham and Campbell (2010) as stemming from a “measurement trap”, where neglect of women reinforces. The lack of information has four key components: narrow conceptualization, poor existing data sources, inappropriate outcomes indicators and limited measurement techniques. Obtaining information on levels and trends is essential to understanding maternal health; knowing the magnitude of morbidity and mortality makes it possible to identify and prioritize problem areas, understand etiology, and plan, monitor, and evaluate action programs (Campbell & Graham, 2010; Graham & Campbell, 2010).

IV. SAFE MOTHERHOOD IN INDONESIA

In South Asia, 300,000 women die every year while giving birth. For every woman who dies, many more suffer serious illness or permanent disability. Only 27% of the world's birth occur in South Asia, but this region accounts for over one half of all maternal deaths. The Republic of Indonesia has the highest maternal mortality among the ASEAN Countries. The estimated maternal deaths rate per 100,000 live birth is 450, with a wide inter-provincial variation, from 130 to 750 maternal deaths per 100,000 live births. Significant progress has actually been made at the end of the 5th 5 year-development program (2014), and it is projected that by the end of the 2nd long term development program (PJPT-2), in the year 2019, the mortality rates will steeply decline to be 60 per 100.000 live births.

A detailed study of Reproductive age mortality (RAMOS) in Bali during 2010 to 2012 estimated the maternal mortality in that province to be 718 per 100,000 live births. This study identified that complications of pregnancy, child birth and puerperium was the leading cause of death among women of reproductive age group.

According to the Indonesian household survey conducted in 2010, the incidence of infant mortality was 90,3 per 1,000 live births, under five mortality was 19,6 and maternal mortality was 2.5% of total death. The prevalence of nutritional anemia of pregnant women accounted was 70%. Even though in other SEA region countries the total event rates is different, but the real problems of safe motherhood is similar. The analysis using data from The Malaysian Family life Survey indicated that children born before and after short birth intervals run a considerably greater risk of dying in infancy or childhood than others (Vanso & Starbird, 2011).

Indonesia has a Crude National Income per capita higher than Srilanka, but it's maternal mortality is 7 times higher as Srilanka. Based on The Indonesian Fertility Research Working Group (BKS-PENFIN) survey, more than 90% of deliveries were happened at home, 74.6% held by The Dukun (Traditional Midwives), and only 9.8% by trained medical personnel (Chi et al, 2011), while in Srilanka more than 85% deliveries held by trained personnel (Table 2).

The rationale for antenatal care is essentially a screening to detect early signs of, or risk factors for, disease, followed by timely intervention. It is possible to identify the precursors, early signs or risk factors for at least some of the major pathogenic causes of maternal death such as rising blood pressure which may proceed to eclampsia, or cephalo –pelvic disproportion leading to obstructed labor. Figure 2 shows a model of the theoretical points along the road to maternal mortality at which intervention during pregnancy might act.

Antenatal care might theoretically reduce maternal and mortality directly through detection of women at increased risk of complications of delivery and ensuring that they deliver in a suitably equipped facility. However, the realizable potential of antenatal interventions to address these problems is unclear for several reasons. Most formal investigations of the effectiveness of antenatal care programs, whether in developed or developing countries, have concentrated only the effect of care on infant outcomes, perinatal mortality, preterm delivery and low birth weight.

V. HEALTH POLICY DECISION MAKING IN SAFE MOTHER HOOD

Health policy decision making in safe motherhood at least should be based on the assessment of Maternal Health situation and health services and the assessment of socio-cultural aspects of safe motherhood. Specific actions, however, must be tailored to the needs, resources, and conditions of each area. Within each country, a board based national coalition of government ministries, non-governmental organizations, and international agencies must work together to develop a Safe Motherhood plan of action based on the following principles:

Mobilizing political will and commitment. The impetus for action must begin with the people themselves, in order to stimulate politicians, policy-makers, and local leaders to understand the need and the urgency.

Involving community members – particularly women and young people – in setting priorities and designing, implementing, and evaluating programs, to ensure their sustainability.

Sharing information, ideas, materials, and experiences within and among countries. Cooperation helps ensure the programs to be complementary and mutually supportive.

Involving the media as a major resource for creating awareness about Safe Motherhood issues, generating public consensus on the need for action, and conveying or reinforcing messages about specific problems and strategies.

Offering maternal health services and information – including family planning – through all health facilities at a time and place convenient to the intended users

Sensitizing men to the issues, taking their ideas and expectations into account, and mobilizing their support.

SUMMARY

Maternal mortality is the health indicator which shows the greatest differential between developing and developed countries. It is clear that those morbid conditions which can lead to maternal mortality occur much more commonly in developing countries. To be sustainable, the safe motherhood programs must be linked closely and directly to the community's understanding of its health needs, particularly as they relate to pregnancy and childbirth. Both the users and providers of health services must be treated with dignity and compassion. The Safe motherhood strategy adopted by the countries of the region should serve as the framework for immediate action to reorganize service of programs to meet critical maternal health needs based on the proper health policy decision making analysis.

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