



THE REPUBLIC OF THE GAMBIA
Ministry of Health

Preventing maternal death: Accelerating progress in achieving ICPD and SDGs: *Experience from The Gambia*

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*Consolidating the Gains and Reaffirming the Commitments
for the Achievement of the ICPD PoA and the SDGs 2030 Agenda*



ICPD
International Conference on
Population and Development
Beijing 1994



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Presentation Outline

- Introduction
 - Location and Geography
- Maternal Mortality
 - Situation and trends in The Gambia
 - Causes, distribution and contributing factors
 - Challenges and gaps in service delivery
- Strategies for prevention
- Conclusion and recommendation

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Location and Geography



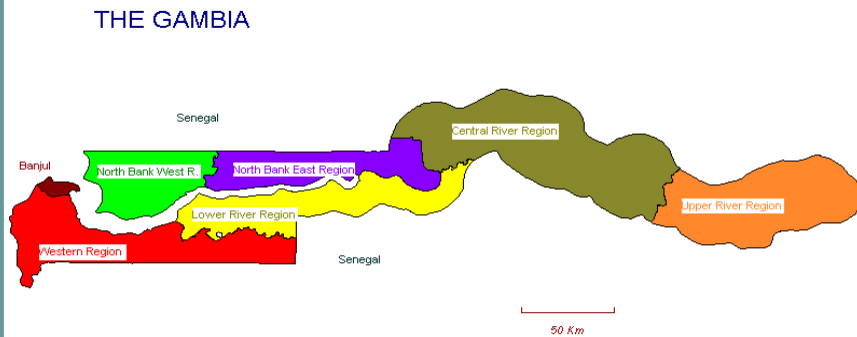
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Location and Geography Contd.



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Administrative Boundaries.



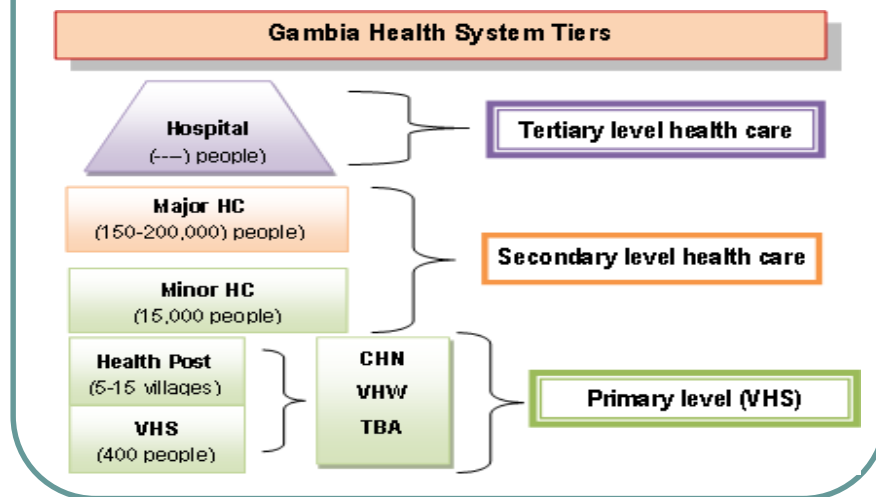
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What is Maternal Mortality?

- When a woman dies from anything having to do with pregnancy, it is called maternal mortality or maternal death.¹ Maternal death can happen while a woman is pregnant, during labor and delivery, or in the 42 days after childbirth or the termination of pregnancy. If a woman passes away from an accident or a health issue that doesn't have anything to do with the pregnancy, then it is not considered a pregnancy-related death.

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Health system



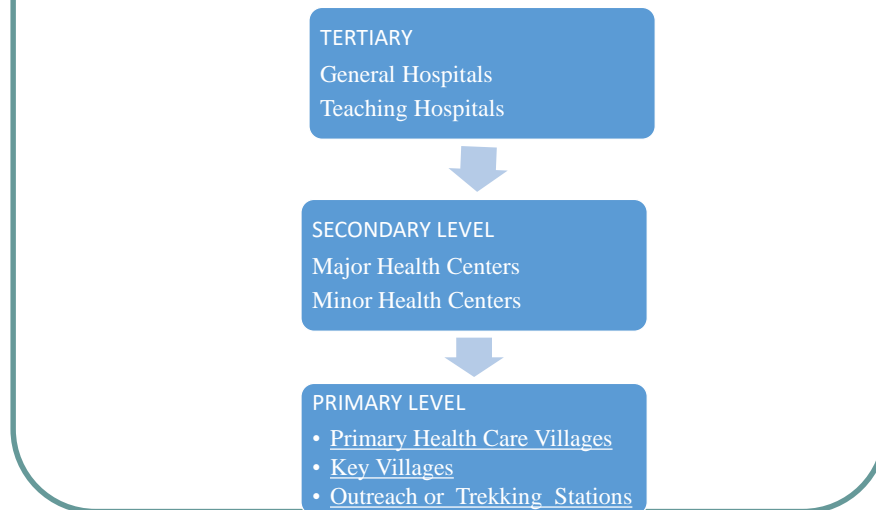
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The Gambia health sector has a three-tier system

- Tertiary (General hospitals (5), Teaching Hospital (1) and Eye Health Hospital (1))
- Secondary (Minor (49) & Major (6) health centers)
- Primary (Village health service (634), community clinics (60) and RCH Clinic sites: (58 base; 257 outreach- 315))

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The Gambia health sector has a three-tier system ctd.



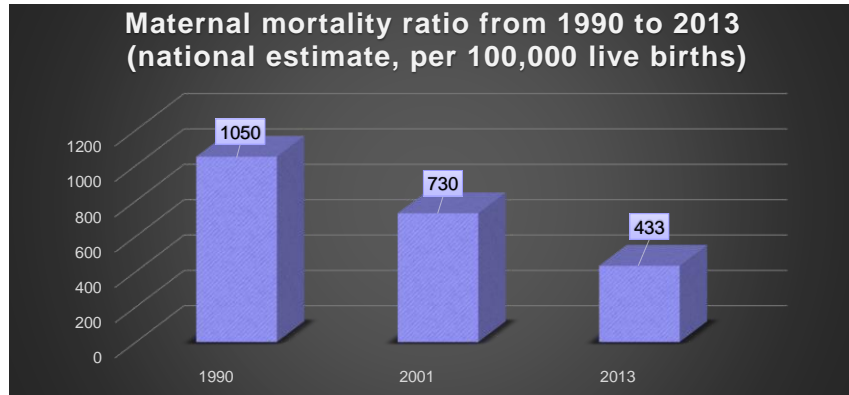
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Mortality: situation and trends

- In the 2013 GDHS, maternal deaths represent 36 percent of all deaths among women age 15-49
- The percentage of female deaths that are maternal varies by age and ranges from 7 percent of all deaths among women age 40-44 to 50 percent of deaths among women age 25-29.
- The maternal mortality ratio was 433 maternal deaths per 100,000 live births.

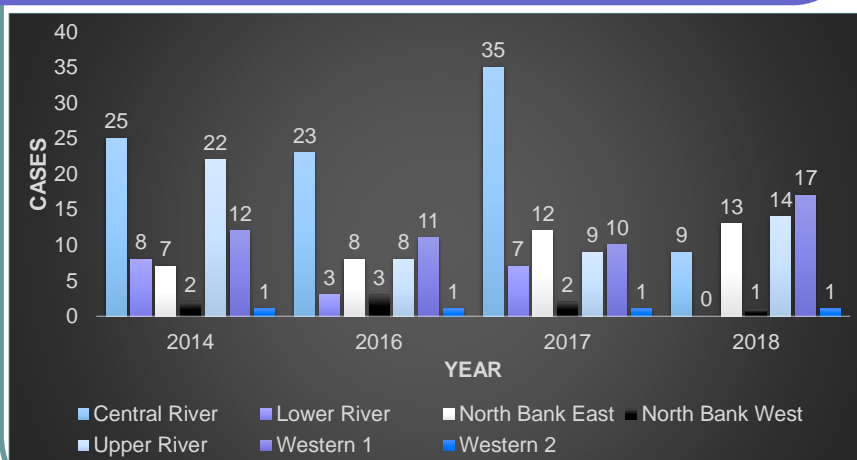
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Mortality: situation and trends cnt.



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Institutional Maternal Death reported by health region, 2014-2018



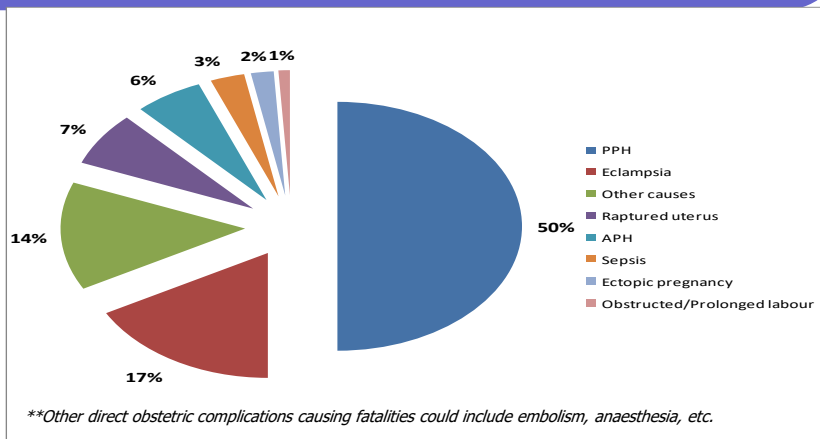
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Causes of maternal death

- The Gambia subscribed to the 75% reduction of MMR by 2015. However, the reduction of MMR in the country has been very slow and remains among the top priority of the country for the post-2015 SDG agendas. Majority of maternal deaths in the country are as a result of avoidable direct obstetric complications, including hemorrhage (37%), hypertensive disorder of pregnancy (11%) and sepsis (11%) (WHO, *et al*, 2015). *The main contributing factors include, inadequate access to CEmONC and BEmONC services, lack of trained human resources, transportation and low socio-economic status of the people.*

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Distribution of institutional maternal deaths due to direct obstetric causes



Source: National Assessment for Emergency Obstetric and Newborn Care 2012

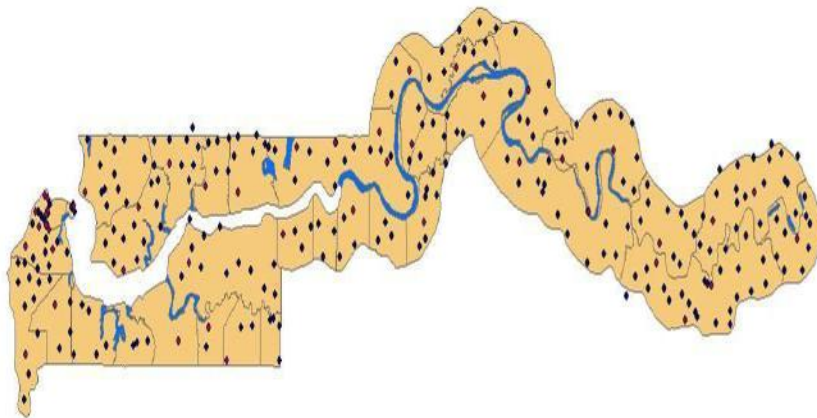
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Why do so many Women die?

- **Three Delays Model**
- Delay in decision to seek care
 - Lack of understanding of complications
 - Acceptance of maternal death
 - Low status of women
 - Socio-cultural barriers to seeking care
- Delay in reaching care
 - Poor communication (roads etc.), islands, rivers — poor health service organization
- Delay in receiving care
 - Supplies, personnel
 - Poorly trained personnel with negative attitude
 - Finances

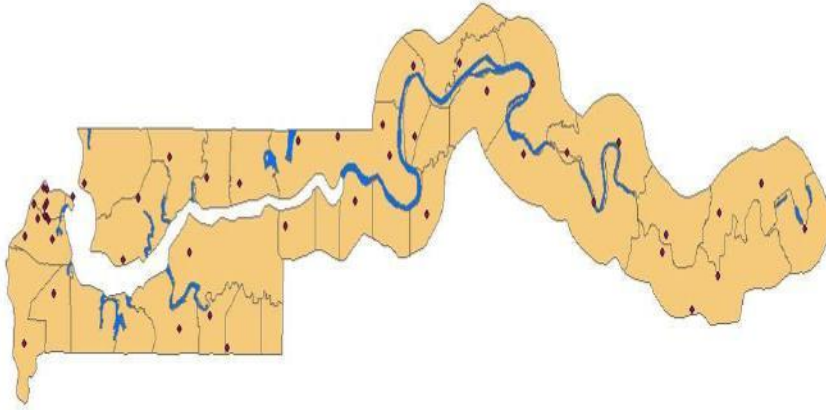
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Distribution of Antenatal Clinics



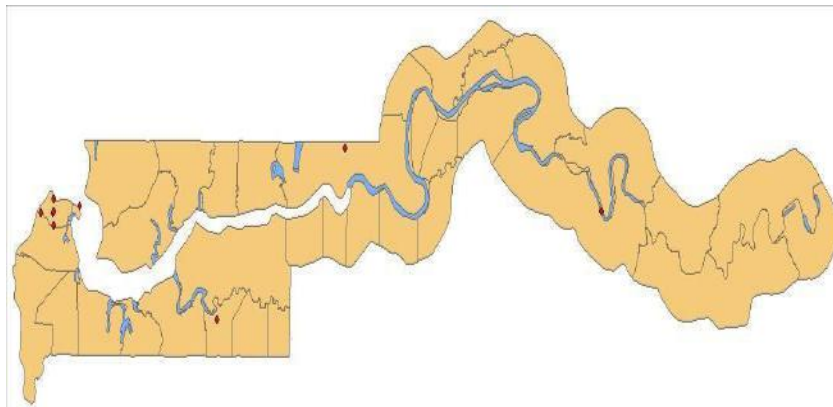
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Distribution of Health Facilities providing Delivery Services



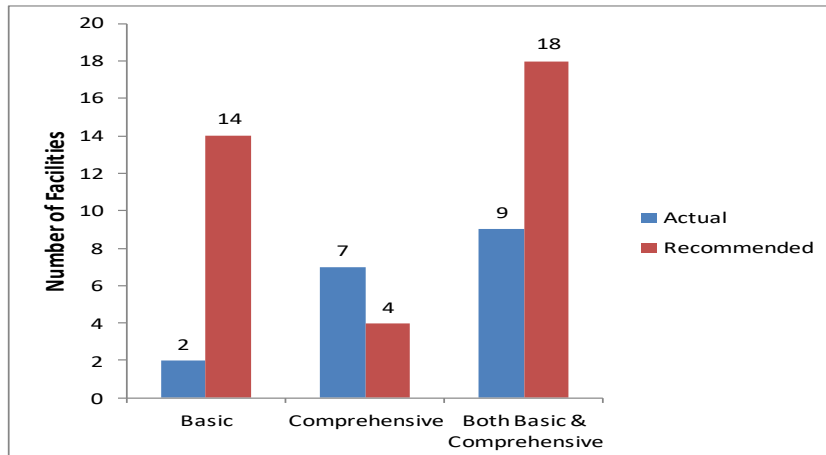
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Distribution of Health Facilities providing Caesarean Section



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Comparison of the actual numbers of EmONC facilities with United Nations targets (per 500,000 population)



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Challenges

- **Poor quality of care**
 - ✓ Huge variability in care
 - ✓ Pregnant women still dying in labor
 - ✓ Poor management of obstetric emergency resulting in complications
 - ✓ Inaccessible emergency obstetric care for rural women
- Inadequacy of resources (financial, material and human) reduced the amount of programme inputs, geographical coverage and efficiency of service delivery
- Structural barriers (cultural denial and resistance)
- Low socio-economic and political status of females

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Challenges contd.

- Poor road networks impact negatively on the hospital referral system leading to delays that are responsible for high maternal morbidity and mortality
- High staff attrition rates due to low morale and poor remunerations
- Difficulties in transportation of patients from community to health facility

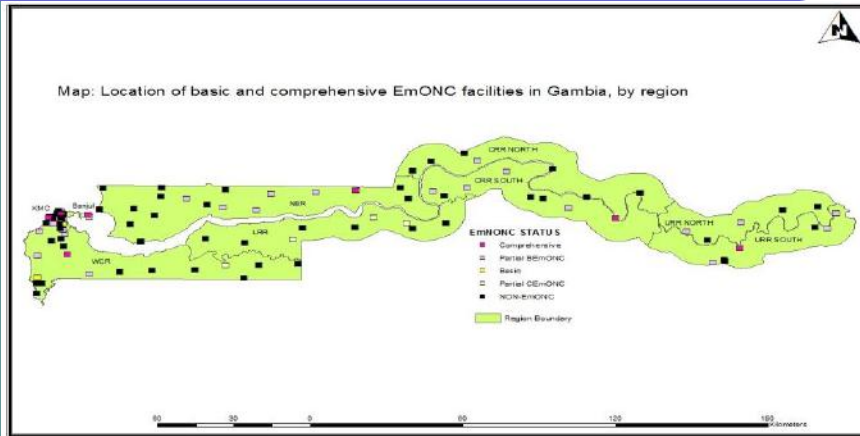
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Gaps in the distribution of EmONC facilities

- Gaps in the distribution of EmONC facilities vary regionally (see Map). They are widest in Kanifing (3), West Coast (2) and Upper River (2). In terms of Comprehensive emergency obstetric and newborn care (CEmONC), facilities in Banjul, North Bank and Central River South regions exceed the recommended number by one.

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Geographic distribution EmONC facilities



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Strategies for prevention

- ***Objective is to contribute to the reduction of maternal, newborn and child mortality through provision of quality health care services that is available, affordable and accessible***
- Strengthening of major and minor health centres for equitable access to both comprehensive and basic emergency obstetric care services, especially in the rural areas
- Improving the availability and quality of comprehensive emergency obstetric care services in all major health centres
- Strengthening the health infrastructure particularly at the primary Health Care level for effective delivery of reproductive and child health services
- Expansion and consolidation of emergency maternal, newborn and child health (EMNCH) initiative

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TAM launched on the 19th February 2009 by HE The Vice President of The Gambia as part of events marking the 44th independence celebrations



Deployment of the first tranche

- 90 motorcycles
- 58 four-wheeled vehicles

The second tranche – May 2009

- 5 four-wheeled vehicles

An **extra 267,500 health service interactions** with community members each year

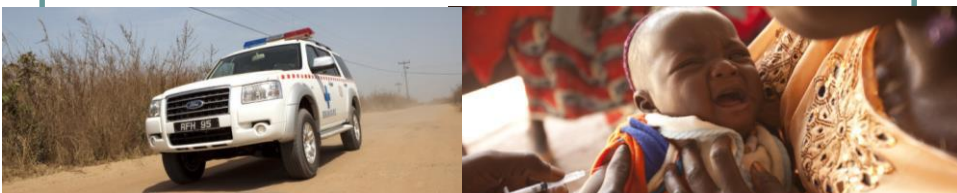


1,250 extra people were referred from health centre to hospital by ambulance in the first year of the TAM programme



Improved vaccine delivery via outreach clinics and mass immunisation campaigns:

- **No outreach clinic cancelled** due to transport or fuel constraints
- A third of health centres (32%) are holding **more outreach clinics** each month
- The immunisation team have maintained **high levels of immunisation coverage**



Introduction of Uhuru community ambulance



The pilot *Uhuru* project was funded by the World Bank Development Marketplace Award. The motorcycle prototype was produced in the UK, but the research, development and production took place in Zimbabwe. Following a long trial of its prototype, the Uhuru was placed in strategic districts in Zimbabwe and The Gambia for further assessment.

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Photos of first Uhuru community ambulances



In The Gambia the first *Uhuru* community ambulance was deployed in Mandinary in March 2005. A second one was deployed in Jahanka in June 2006 and the third in Kankurang in September 2007.

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A third generation of the *Uhuru* community ambulance



This version is a three-wheeled vehicle adapted with siren and flashing lights designed to carry a stretcher and two escorts. Riders for Health has purchased 10 of these vehicles assembled at their headquarters in Kanifing. In consultation with the Regional Health Directorates, the 10 community ambulances have been deployed to the various locations in the country

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Two *Uhuru X* community ambulances were placed at Basse and Kuntaur Major Health Centres in April 2014



The *Uhuru X* is based in a health centre and serves the catchment area communities of the facility. For utilization to be effective Riders for Health provided mobile telephones to all the Traditional Birth Attendants (now known as Community Birth Companions) within the catchment area communities, under a Closed User Group (CUG) system. Both the Nurse Midwife and the driver of the *Uhuru X* were included within the health centre CUG phones. TBAs call the Nurse Midwife to request for the *Uhuru X* community ambulance, who in turn calls the driver directing him to go for the pregnant woman.

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Better access to health care for 1.9 million men, women and children across the Gambia.

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Conclusion and recommendation

- “My legacy goal is to establish a healthcare delivery system for our people, that is robust, efficient and responsive to the needs of our people based on the principles of universal healthcare with emphasis on Primary Health Care to reduce maternal mortality ratio from 433 to less than 200 per 100,000 live births, under-five mortality rate from 54 per 1000 to less than 30 per 1000 live births and also to reduce the incidence of Non-communicable diseases by the end of 2021”. **By Dr Ahmadou Lamin Samateh, Hon, Minister of Health –The Gambia**

@ the 2019 Harvard Ministerial Forum-Defining a Ministerial Legacy

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The End

- Abaraka

Jerejeff

Thank you

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