Ankara, 20 Mart 2015

2015 ve sonrasında anne ve yenidoğan sağlığı hedefleri

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World Health Organization

human reproduction programme hrp
research for impact
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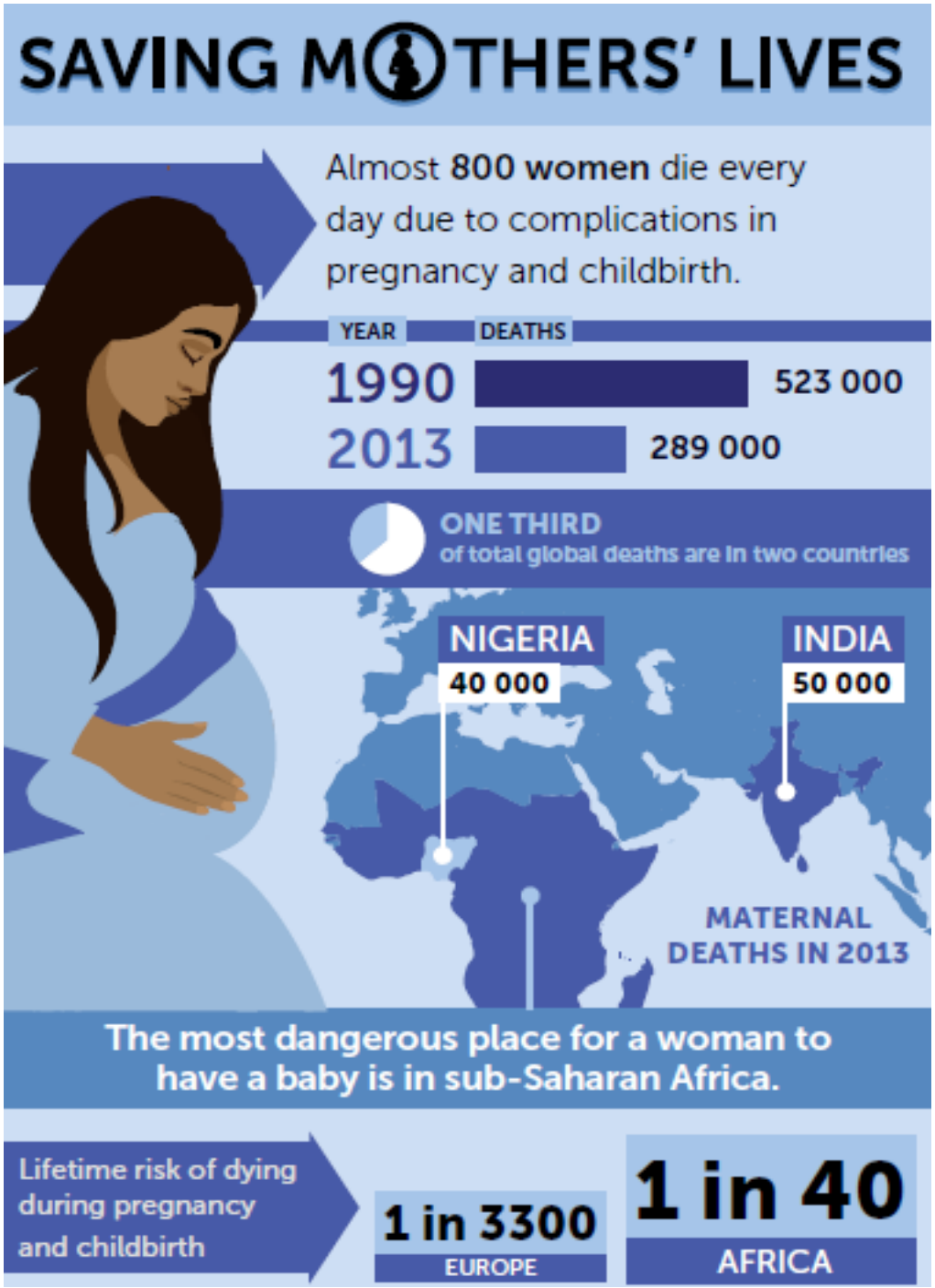
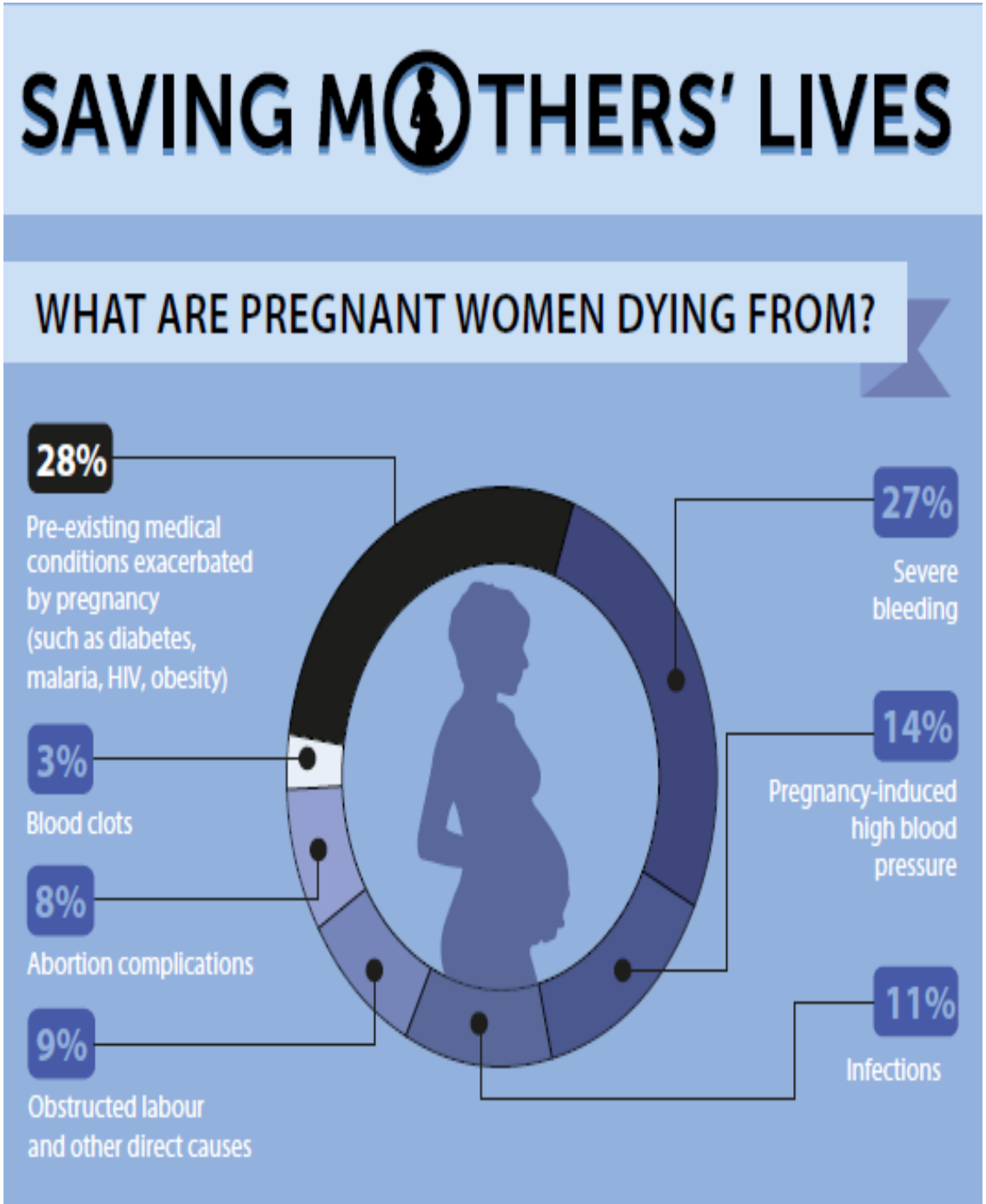
Binyıl Kalkınma Hedefleri (MDG)

- Geniş tabanlı anlaşmalara dayalı küresel boyutta hedefler koymak değişiklik ve ilerleme açısından önemli bir katalitik etki yapabilir
- Zaman-sınırlı hedef ve indikatörler başarının derecesini ve yerini izlemek açısından yararlı olmuştur
- Eşitsizlikleri maskelemek hatta artırmak gibi potansiyel zararları da olabileceği görülmüştür





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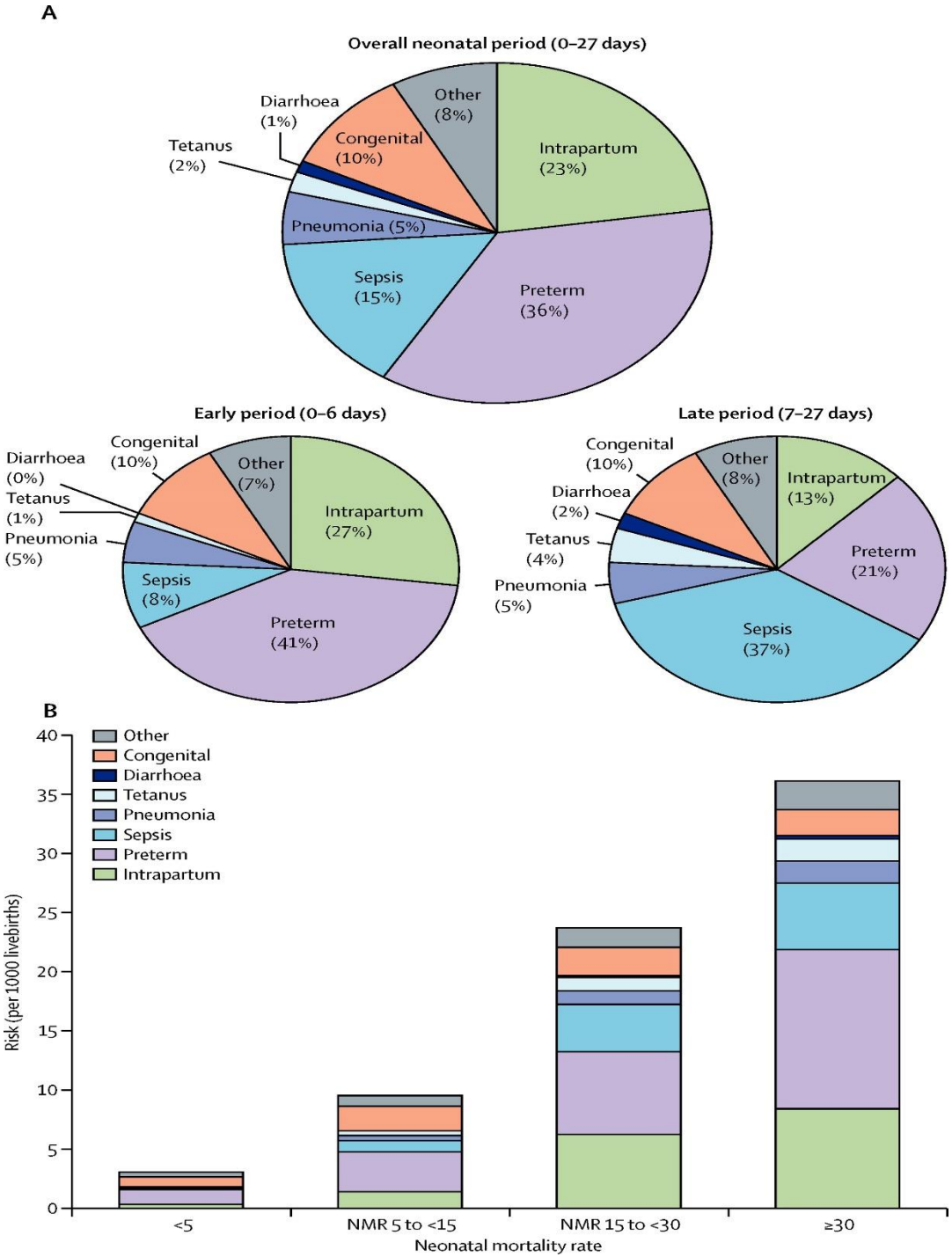

A
Overall neonatal period (0–27 days)
Other (8%)
Diarrhoea (1%)
Congenital (10%)
Tetanus (2%)
Intrapartum (23%)
Pneumonia (5%)
Sepsis (15%)
Preterm (36%)
Early period (0–6 days)
Congenital (10%)
Other (7%)
Diarrhoea (0%)
Tetanus (1%)
Intrapartum (27%)
Pneumonia (5%)
Sepsis (8%)
Preterm (41%)
Late period (7–27 days)
Congenital (10%)
Other (8%)
Intrapartum (13%)
Diarrhoea (2%)
Tetanus (4%)
Preterm (21%)
Pneumonia (5%)
Sepsis (37%)
B
Other
Congenital
Diarrhoea
Tetanus
Pneumonia
Sepsis
Preterm
Intrapartum
Risk (per 1000 livebirths)
0
5
10
15
20
25
30
35
40
<5
NMR 5 to <15
NMR 15 to <30
≥30
Neonatal mortality rate

2000-2015 yıllarında anne ve yenidoğan sağlığı konusunda ana girişimler

- Doğumda yeterli bilgi ve becerisi olan birisinin bulunması
- Yaşam kurtarıcı tedavilerin kanıt bazını geliştirmek
- Önemli girişimlerin kullanımını artırmak
- Sağlık hizmetlerine ulaşımı artırmak
  - Maddi düzenlemeler
  - Sağlık birimleri arasında transferleri düzenlemek
- Kordon bakımı
- Sepsis
- CPAP
- Skin to skin / KMC

Global Strategy for Women's and Children's Health

Küresel MMR hedefi 2030 yılında < 70

World Health Organization

hrp

Targets and Strategies for Ending Preventable Maternal Mortality

consensus statement

Every day approximately 800 women die from preventable causes related to pregnancy and childbirth

Overview

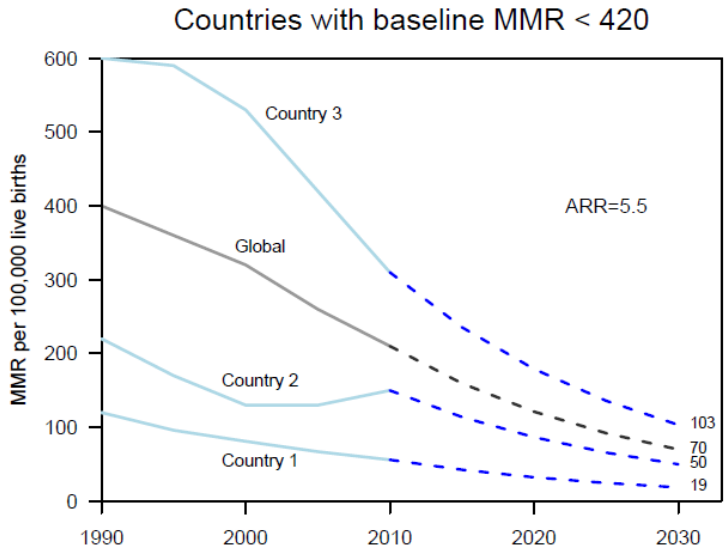
- In April 2014, representatives from UN agencies, country governments, development partners and other stakeholders came together in Bangkok for a "Consultation on Targets and Strategies for Ending Preventable Maternal Mortality (EPMM)". The aim of the consultation was to forge consensus on maternal mortality reduction targets for inclusion in the post-2015 development agenda as well as to identify maternal health strategies that will assist countries to achieve those targets. The discussions were the culmination of earlier technical consultations which employed specific analytical methods to define feasible maternal mortality targets and goals.
- Convened by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), the Maternal Health Task Force (MHTF), and the Maternal and Child Health Integrated Program (MCHIP), with support from agencies and donors and input from the EPMM Working Group, the meeting was attended by over 95 participants from 34 countries, most of them challenged with high rates of maternal mortality.
- The Consultation affirmed that EPMM is within reach and that the necessary acceleration of progress can be achieved by positioning maternal survival in the context of every woman's right to healthcare and the highest attainable level of health across the lifespan. This goal must be supported by targets and strategies for the post-2015 development agenda, since maternal health as part of the continuum of sexual and reproductive health, along with newborn and child survival, are crucial elements of development.

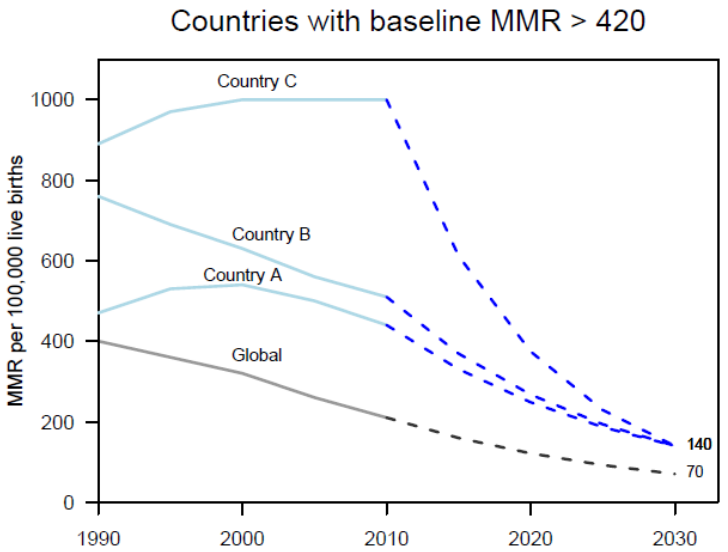
World Health Organization · hrp · unicef · UNFPA · FIGO · USAID · THE WHITE RIBBON ALLIANCE · FAMILY CARE INTERNATIONAL · International Confederation of Midwives · Maternal Health Task Force · MCHIP Maternal and Child Health Integrated Program

World Health Organization · hrp

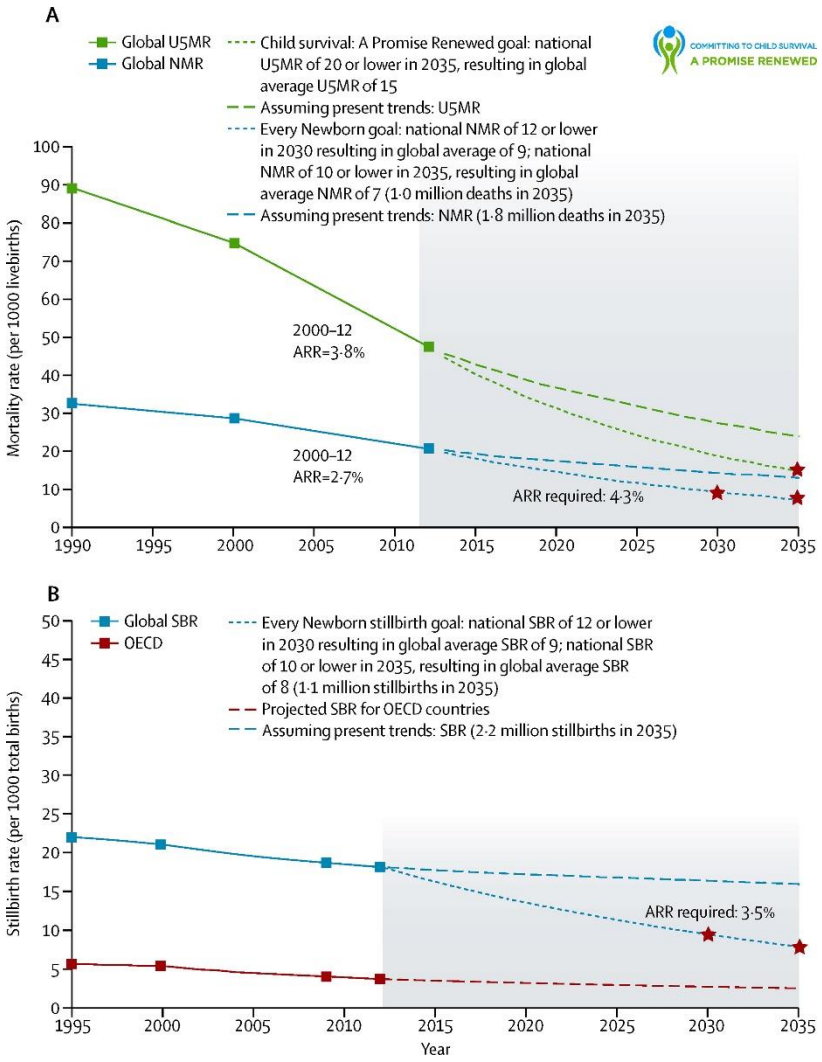
Üzerinde anlaşılan 2015 sonrası küresel hedefler

1. **Küresel MMR 2030 < 70**
   - 2010 ve 2030 arasında küresel MMRı üçte ikiden fazla düşürmek
   - Küresel MMR düşüş beklentisi ülkeler arası ortalama olarak alınacak
2. **Ülkeler de 2010'dan 2030'a kadar üçte ikiden fazla MMR düşürmeyi hedefleyecek**
   - Ülkeler arası beklenti aynı oranda olacak (>2/3)
   - 2030 için ülke hedefleri farklı olacak





Küresel yenidoğan hedefleri: 2035



Anne sağlığını iyileştirmede yeni hedef ne olmalı?

- Mortalite nedenleri ve yerleri giderek değişiyor
- Mortalite düştükçe morbidite üzerine odaklanma gereği artıyor
- Morbidite ve hastane doğumlarına odaklandıkça sağlık hizmetlerinin kalitesine daha fazla önem vermemiz gerekiyor

Maternal near miss konseptinin doğuşu, gelişimi ve olgunlaşması

- Prevalans sistematik derlemesi (2004)
- DSÖ tanım ve tesbit kriterleri (2009)
- DSÖ kriterlerinin geçerliliğinin gösterilmesi (2011)
- DSÖ kriterlerine uygun izleme kılavuzu (2011)
- 29 ülkede, 357 hastane ve > 300,000 kadında yapılan anket çalışması (2013): **Esansiyel tedavilerin kulanılıyor olması anne ölümlerini düşürmek için yeterli değil!**

Are Institutional Births Institutionalizing Deaths?

SUBMITTED BY JISHNU DAS ON THU, 11/20/2014
CO-AUTHORS: JEFFREY HAMMER

11 COMMENTS

On November 12th in the Indian state of Chhattisgarh, twelve women who had received tubal ligations died. The tragic incident highlights the unfortunate reality that for many people around the world, hospitals and clinics may not satisfy the most basic assumption that visiting them will make you better. Equally worrying is the Indian government's singular focus on increasing 'institutional deliveries' and family planning that led it to celebrate a surgeon who had performed 100,000 sterilizations, now spending no more than 4 minutes on each "case".

Around 9 am one of us (Das) arrives at the Community Health Center in a small town in Madhya Pradesh, India. There is a row of women lying on the floor outside the labor and delivery room, moaning or groaning in various stages of pain and clear discomfort. We pay them no heed; this is a sight we have seen before. Over two years, we have visited many health facilities in the state and they are either (i) deserted or (ii) packed to the brim with women giving birth, about to give birth, or just having given birth. Mass tubal ligations are performed on as many women as will consent—aided by the promise of money under India's conditional cash transfer for institutional delivery—which, till recently would not pay women who were giving birth to a third or higher parity child unless they also consented to be sterilized. The obstetrician/gynecologist is happy to show us around. She is young and clearly exhausted. "I came here 5 months back. Since then, I have been alone with one nurse in this facility. Every month we do 1,000 deliveries and around 500-600 tubal ligations; almost 100 are C-sections. I am here 18 hours a day and even then at 2 every morning I stay up bleaching the operating room." She shows me the bleach and the OR is truly spotless. She tells me that she is looking for the first opportunity to leave—either by pursuing a specialization or leaving public service. "This is no way to help. I thought I would work on improving people's lives. But there is no help from the government and I can't keep this up much longer".

A short 30-minute drive away, we visit the nearest Primary Health Care center. A young man is waiting next to a motorcycle. He has been crying. "I brought my wife here to give birth last night. But when the child was born, the doctor said that he did not have sufficient oxygen. He told us to take the child to the district hospital. I rushed my child there on the motorcycle, but by the time a doctor saw the child it was too late. No one cared. This doctor is not bothered. If only he had worried a little. He just did not care." He keeps repeating the same phrase again and again: "No one cared" and it remains with us for a while.

Spurred by an international consensus that the way to meet the Millennium Development Goals on reductions in maternal, child and infant mortality was to increase the number of institutional deliveries, countries have devoted themselves with a single-minded focus to doing just that. The Indian Government, encouraged by the "success" of the Chiranjeevi voucher scheme , expanded conditional cash transfers for institutional deliveries to the entire country. In Rwanda, facilities were paid for institutional deliveries. The results have been impressive. Between 2005 and 2011 (the last year for which public data are available in India), institutional deliveries increased from 20% to 49% in nine Indian states with relatively worse socioeconomic and health indicators. Similarly, between 2000 and 2008 in Rwanda, institutional deliveries increased from (approximately) 25% to 75%. What has the fast rise in institutional deliveries done to child mortality?

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Recent comments

- I am a doctor in human 1 day 17 hours ago
- In INDIA the main problem is 4 days 21 hours ago
- All these predictions are not 1 week 1 day ago
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- Good suggestions.Youth with 1 week 6 days ago
- You are absolutely correct. 2 weeks 14 hours ago
- Hi Ed, no this is a mistake. 2 weeks 15 hours ago
- Toss-A-Coin Development 2 weeks 1 day ago
- Any reason for redefining the 2 weeks 1 day ago

Archive

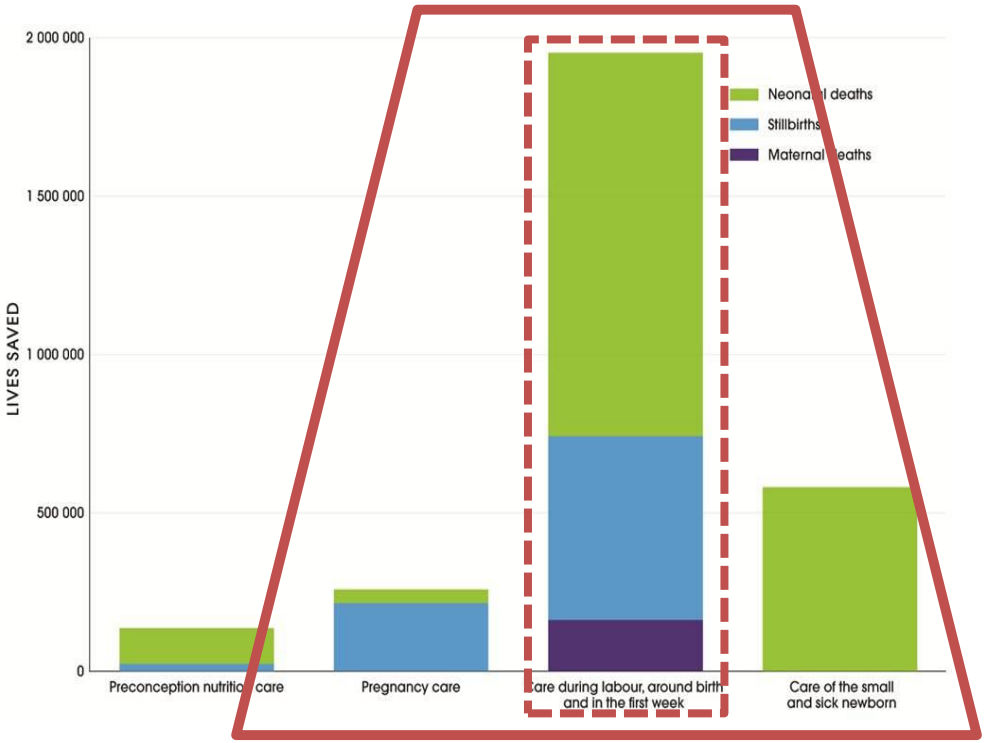
- January 2015 (2)
- December 2014 (10)

DSÖ hizmet kalitesi tanımı

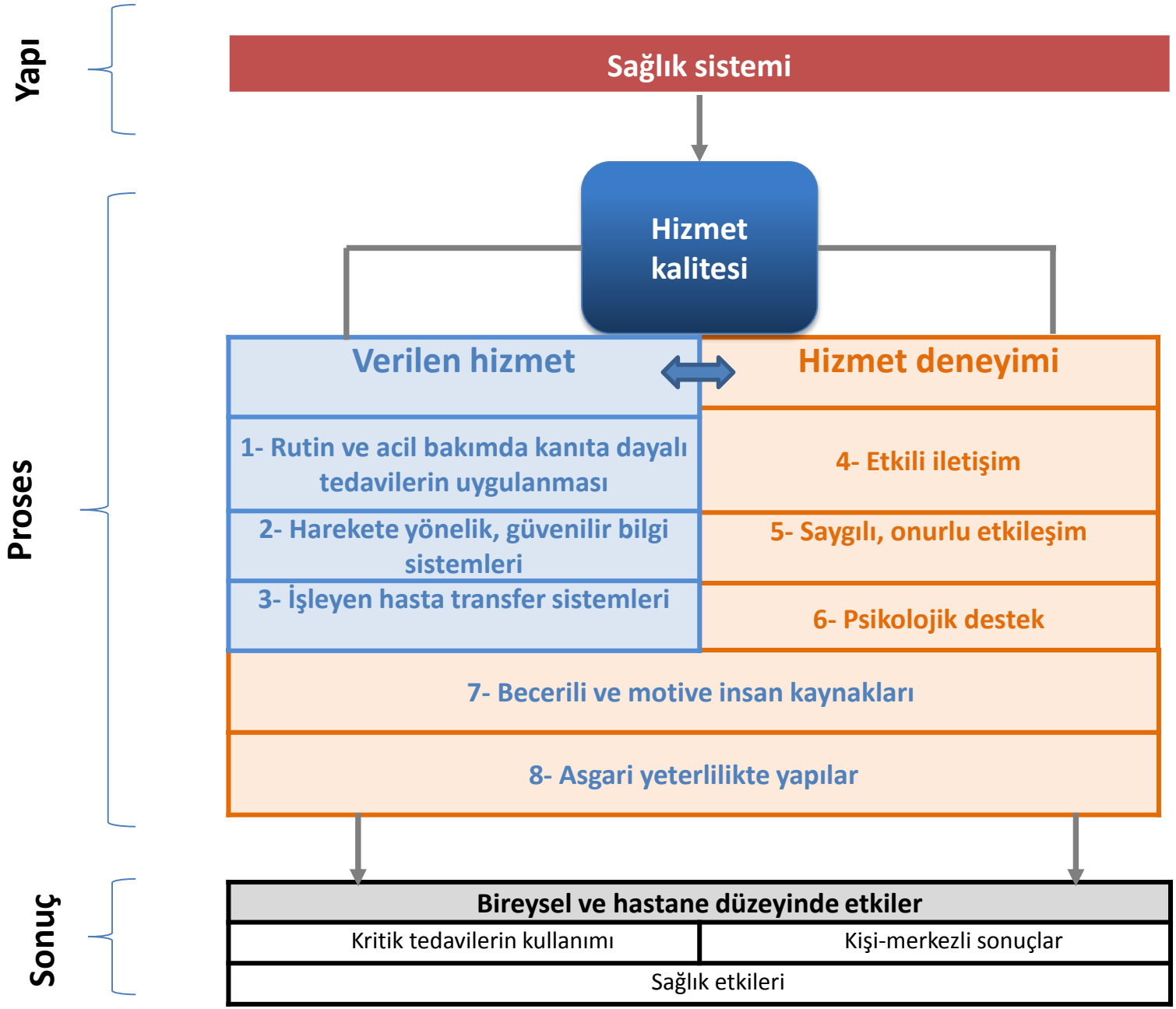
Hizmet kalitesi kişilere ve topluma sağlanan sağlık hizmetlerinin istenen sağlık etkilerini gösterebilmesi ile anlaşılır. Bu amaca ulaşabilmek sağlık hizmetinin **güvenilir, etkili, zamanlı, etkin, eşitlikçi ve kişi-merkezli** olmasıyla mümkündür.

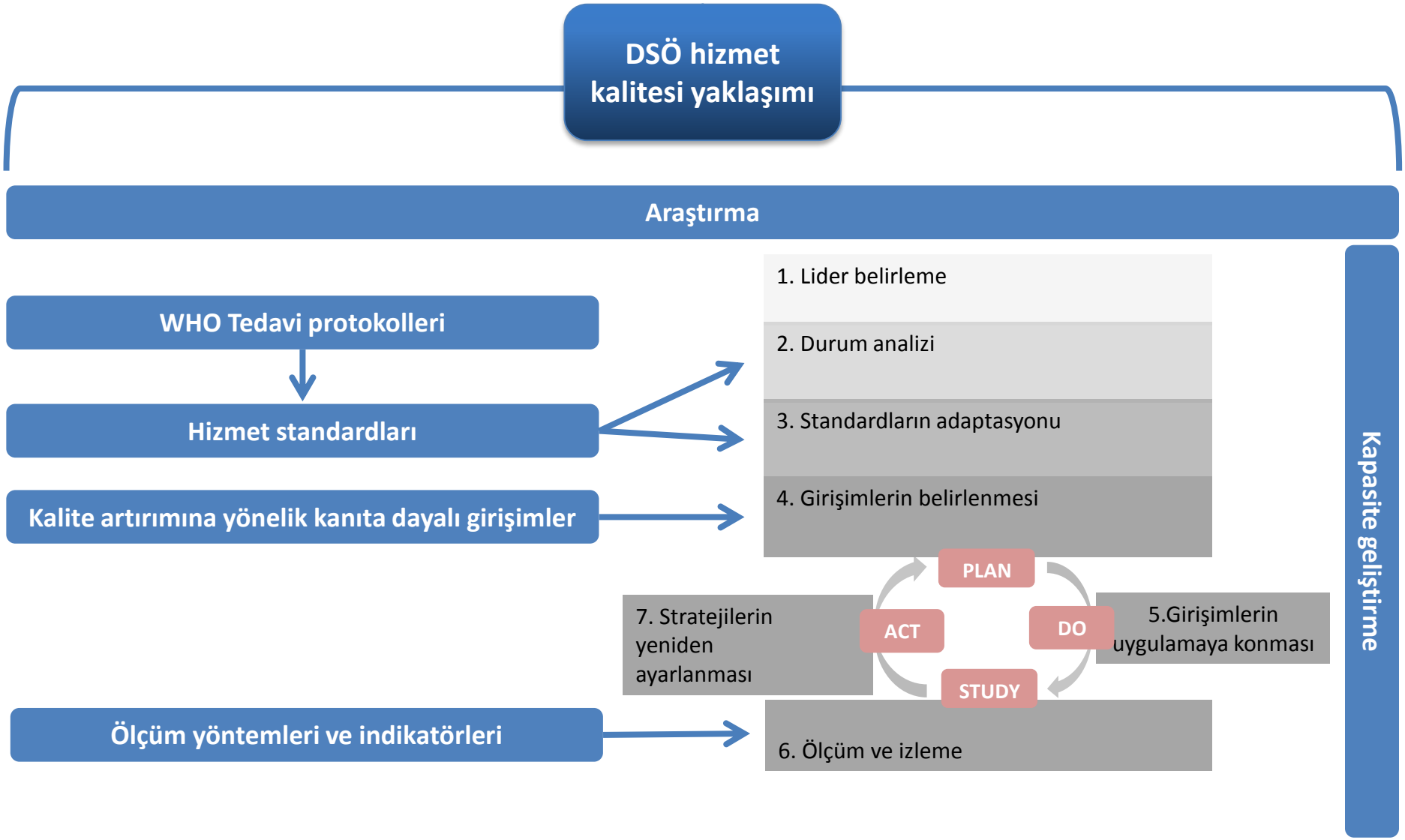
Anne ölümlerini, ölü doğumları ve yeni doğan ölümlerini azaltmak için doğum ve civarı en önemli zaman dilimi

- Gebelik bakımı
- **Anne ve yeni doğan açısından 'doğum' zaman aralığı**
  - **Intrapartum bakım**
  - **Erken doğum**
- Küçük ve hasta yeni doğan bakımı



Bhutta ZA et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? Lancet. 2014;384(9940):347-70.


Yapı
Proses
Sonuç
Sağlık sistemi
Hizmet kalitesi
Verilen hizmet
Hizmet deneyimi
1- Rutin ve acil bakımda kanıta dayalı tedavilerin uygulanması
2- Harekete yönelik, güvenilir bilgi sistemleri
3- İşleyen hasta transfer sistemleri
4- Etkili iletişim
5- Saygılı, onurlu etkileşim
6- Psikolojik destek
7- Becerili ve motive insan kaynakları
8- Asgari yeterlilikte yapılar
Bireysel ve hastane düzeyinde etkiler
Kritik tedavilerin kullanımı
Kişi-merkezli sonuçlar
Sağlık etkileri


DSÖ hizmet kalitesi yaklaşımı
Araştırma
WHO Tedavi protokolleri
Hizmet standardları
Kalite artırımına yönelik kanıta dayalı girişimler
Ölçüm yöntemleri ve indikatörleri
1. Lider belirleme
2. Durum analizi
3. Standardların adaptasyonu
4. Girişimlerin belirlenmesi
PLAN
DO
STUDY
ACT
5.Girişimlerin uygulamaya konması
6. Ölçüm ve izleme
7. Stratejilerin yeniden ayarlanması
Kapasite geliştirme

Yorum

- Önümüzdeki 15 yılda klinik araştırmalara ek olarak daha fazla oranda çok boyutlu ve multi-disipliner yaklaşımlara gerek duyulacak
  - Sadece tedavilerin uygulanabildiğinin gösterilmesi yeterli olmayacak
  - Mortalite yanısıra morbiditeyi hem ölçmek hem de azaltmak önem kazanacak
- Hizmet kalitesini ölçme ve iyileştirme konusunda öok daha fazla araştırmaya gerek duyulacak
  - Bu bağlamda hem tedavilerin sağlanması, hastalara ulaştırılması hem de kadın, aile ve hastaların sağlık sistemiyle karşılaştığındaki deneyimlerini anlamak ve ölçmek önemli olacak

Teşekkürler!