Critical Review of a Journal Article

Student’s Name

Institutional Affiliation

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Maternal and neonatal deaths, as the maximum expression of the complications of pregnancy, delivery and puerperium, are still a serious public health issue in the world, and the article presented by Kildea et. al (2010) specifies Australia concerning indigenous and non-indigenous population. Despite it is highly unavoidable problem and has been reduced considerably in some countries, in others (and in some vulnerable areas within countries) little progress has been made, and so much remains an unfinished agenda. There are strategies and means that can be highly effective, as knowledge and experience indicate, and which are applicable even in those population groups that are more vulnerable and susceptible to getting sick and dying from highly avoidable pregnancy and childbirth. The article of Kildea et. al (2010) is chosen for critical review and other sources to understand the context in a profound manner. Although they are not diseases, but they are at risk of complication, especially during the process of childbirth maternal emergencies are extremely difficult to predict, which is why all women need access to essential obstetric care.

It is worthy of a note that non-indigenous Australian women have more maternity mortality rate than the indigenous women. According to Kildea et. al (2010), it can be thoroughly achieved by applying the effective approach; for instance, the application of the adaptation of policies of those countries who faced the similar gap and improved their situation will have effective benefit in Australian healthcare situation. The adoption of the necessary measures to achieve a safe birth can significantly reduce the risk of complications and death of the mother and the newborn. In turn, the neonatal period (especially immediately after the birth) represents the most vulnerable and critical moment of the first year of life. According to Rhodes (2016), through appropriate and effective interventions, around safe motherhood and safe births, one can not only reduce mortality and morbidity, but can contribute to better health, quality of life and equity. Therefore, despite the progress still pending, there is more and more conviction that the reduction of maternal and neonatal mortality can be gradually and effectively achieved, if has a set of effective and coordinated strategies.

It is necessary to strengthen the health interventions of the mother, the newborn and the child based on evidence, including information about the manner, place, time and reason of the deaths neonatal diseases, in order to allow the development of better policies and activities to promote the cause, establish more focused priorities and increase programmatic effectiveness at the service and delivery levels community (UNFPA, 2017a). According to WHO (2015), without these components, it will be impossible to substantially reduce maternal mortality and neonatal Among the effective strategies include:

1. development and application of appropriate and sustainable public policies and mechanisms of social protection;
2. strengthen health systems to ensure access to essential obstetric care effective, including qualified delivery and newborn care;
3. strengthen community health, in different cultural areas, and promote care primary health;
4. empower and educate women, their families and their communities for a healthy life and take timely decisions on the use of health services;
5. establish partnerships and joint efforts at national and international level, based on the principle of UN health reports and “closing the gap”; and
6. strengthen information systems and epidemiological surveillance of maternal deaths and neonatal.

To achieve the necessary and urgent progress in the region, a solidarity effort is required that involves to the set of governments, society and international agencies, and alliances in the FTA. In this meaning, the United Nations and the countries of the world have committed to achieving by 2015 a group of the Millennium Development Goals, including the reduction of two-thirds mortality child health and the improvement of maternal health (with emphasis on reducing maternal mortality by half and increase in skilled birth care coverage).

Even in the modern countries, such as America, Europe, and Australia, direct obstetric causes of death predominate, exceeding 70%. Between these primary medical causes include hemorrhage (25%), septicemia (15%), complications of the abortion (13%), eclampsia (12%) and obstructed labor (8%). Women with obstetric complications; they usually die within 48 hours. Deaths caused by hemorrhage and septicemia are more related to the birth itself. The hypertension of pregnancy is a risk of maternal morbidity and mortality. Abortion, especially that which is provoked, is an important public health problem (WHO, 2015). These complications are directly related to the lack of access or use of services of maternity. In addition, services often cannot respond to emergencies, and the quality of one’s attention is sometimes deficient.

As per the WHO (2015) report, HIV / AIDS infection is also a contributor and an indirect cause of maternal death. In the modern countries, it is estimated that 1.4 million adults and children currently suffer from infection with HIV AIDS. A quarter of HIV-positive adults are women. The Caribbean is the most badly affected of the Region whilst Australia present some of the greatest inequities, in terms of indigenous and non-indigenous, in maternal mortality in the world. For example, in Australia there are only 4 maternal deaths per 100,000 live births, compared to 523 in Haiti. Chile has a maternal mortality rate of 23 per 100,000 live births, compared to 390 in Bolivia. Official estimates indicate that the rates are less than 100 per 100,000 live births in Brazil, El Salvador and the Dominican Republic. However, under-reporting of official statistics is a serious cause for concern, WHO has adjusted maternal mortality rates for 14 countries, from so that they reflect more accurately the magnitude of the problem.

In addition, maternal mortality varies. Among such issues, there is a low average prevalence of contraceptive use (65%) and during pregnancy, 89% of women has at least one prenatal visit. On average, although it varies widely by country, 79% of deliveries in Australia and the Canada have place in health facilities. 87% of deliveries are attended by qualified personnel. In zones rural areas, on the other hand, access to supplies, equipment in operation and referral services is limited (Kildea et. al, 2012010; WHO, 2015; UNFPA, 2017a). It is the main reason for the Aboriginal and Torres Strait Islander mothers as they are poorer population and live majorly in remote areas.

In addition, a significant proportion of births in rural areas can be cared for by auxiliary nurses who do not have the necessary midwifery training. Even the "midwives trained "may not always have the level of competence required to effectively solve the problems of both the mother and the newborn. In countries where one stop mainly in the home, neonatal mortality rates are the highest. According to demographic and health surveys, the highest proportion of deliveries at home is in Haiti (77%), Guatemala (60%), Honduras (44%), Bolivia (40%) and Nicaragua (33%). These deliveries are usually attended by a traditional midwife or, in some communities, by a member of the family (UNFPA, 2017c; UNFPA, 2017b). The similar approach is evident in the rural areas of Australia, where hospitals and other health facilities are often discharged from mothers and their newborns in the six hours after delivery, although their chances of suffering a complication is high that could endanger their life. In general, rules and protocols are lacking for care of high-risk newborns, such as premature babies and those with low birth weight, or those who were revived (Rhodes, 2016). According to WHO (2015) and Kildea et. al (2010), in some countries like Australia, and because of the practices in relation to childbirth and the puerperium, there is a tendency to isolate mothers and newborns inside their homes for variable periods of up to six weeks. The lack of autonomy of women, lack of awareness of maternal and child needs, difficulties in transport and poor quality of care in some of the services are some of the issues faced by non-indigenous Australian.

According to Kildea et. al (2010) and similarly affirmed by UNFPA (2017a), the goals of safe motherhood are: protect and promote reproductive rights and rights reduce the global burden of disease, disability and unnecessary death that are associated with pregnancy, childbirth and puerperium; improve the conditions for women to have a birth without risk and healthy; and ensure that all children have the same possibilities since their beginning in the lifetime. The strategies focus on a continuous focus on the care of women, newborns and children, in a safe motherhood and safe births. According to Rhodes (2016), this translates into the need to integrate programs and actions in health, and the integration of the health services network, primary care and participation active and empowered of women and the community. The effectiveness required is based on best practices and lessons learned, including calculating the costs necessary to achieve cost-benefit actions and allow programs to be sustainable, accessible and of essential quality.

WHO (2015), UNICEF and UNFPA recommend that for every half a million people there are four centers that offer basic essential obstetric care and one with comprehensive obstetric care, that include greater technological complexity. Main types of assistance to provide are:

1. timely and scheduled prenatal care by trained personnel;
2. medical treatment of complications related to pregnancy, delivery or abortion (hemorrhage, septicemia, complications of abortion, eclampsia);
3. manual procedures at the time of uncomplicated delivery, to prevent and treat infections, hemorrhages and obstructed labor;
4. according to necessity, surgical interventions (especially cesarean section), anesthesia and transfusion blood;
5. basic neonatal care.

It is important that health services have adequate networks that allow reference in case if more complex maternal and neonatal care is needed (such as surgery, transfusions, care of newborns with problems, especially very low birth weight) with systems of emergency transport. WHO and the World Bank have calculated that the set of ordinary health measures of the mother and the Newborn would cost approximately US $ 2.60 per person per year in a low-income country (WHO, 2015). These costs are mainly those of maternal health services (68%), but also include postpartum family planning and basic neonatal care, as well as the promotion of condoms for prevent sexually transmitted infections.

The care from the period prior to pregnancy to the puerperium and the postnatal period by a qualified health worker - preferably with midwifery or midwifery training - aimed at adolescents and women of childbearing age, and that includes immunization against tetanus and rubella, treatment of genital infections, orientation for the birth and preparations for situations of emergence, upbringing and spacing of births (Kildea et. al, 2010). The assistance of a health agent with Midwifery training responsible for prenatal care, optimal care for the mother and the newborn born during labor, delivery, puerperium and postnatal period, are fundamental points in the continuum of care and should be closely linked to an effective reference to the child health services after the first month of life an economic intervention to stop the spread of HIV is the prevention of transmission maternal and child health (PMTCT). Good quality prenatal care is a key point of access to care and treatment of HIV infection. If integrated into prenatal care, the PMTCT can prevent at least 50% of HIV infections in children and can contribute to the identification timely and referral of women for treatment with antiretroviral (ART) (WHO, 2015).

Currently, several countries in Latin America and the Caribbean offer PMTCT in 100% of their prenatal services. Maternal mortality can be reduced by the synergistic effect of combined interventions in a strong political framework for health promotion. According to Kildea et. al (2010), improvements in the health system are vital, since women are dying at the level of service provision for the lack of an obstetric network that goes from the community level to the highest level of obstetric complications. Ensure community access to data on maternal and newborn health and involve it in improving quality of care are examples of community partnerships that contribute to the program have demand and be sustainable. Communities that actively collaborate with health programs maternal develop a sense of ownership and a personal interest in its success. This approach is a part of the process of improving health and reducing maternal and neonatal mortality. As per the assessment of the UNFPA (2017a) and UNFPA (2017b), effective empowerment and participation and communication strategies including community are They need to contribute to program planning health of the mother and newborn, as well as strengthening providers, interpersonal and intercultural skills, using methods popular communication and media to ensure adequate home care and translate the demand for care and treatment from the community in a reduction neonatal mortality. As per the framework of Rhodes (2016) and UNFA (2017b), to improve maternal health, it is necessary: ​​

1. include women and communities in the design and evaluation of services to respond to local needs;
2. engaging the communities in efforts to improve women's access to maternal care culturally acceptable;
3. empower communities, families and women to take the measures necessary for safe motherhood. This should be done in a strong policy framework Health promotion

Women's empowerment allows them to choose their own alternatives and provide adequate information to make crucial decisions regarding their health and, therefore, exercise their rights. That allows them to promptly recognize risks and complications, follow medical and benefit from health education programs procedures (UNFPA, 2017c). Strengthening partnerships through a participatory plan needs to include global partnerships, regional, national and local, with ministries of health, donors, aid agencies international, and other key stakeholders comprising civil society and non-governmental organizations.

Summing up, local and national governments, health services, the professional associations, women's organizations and other NGOs should be involved and promoted as key partners in efforts to reduce maternal and neonatal mortality. In this context, “closing the gap” and other technical cooperation focuses on policy, promotion the cause of family and community health, service delivery, training resources human, support for resource mobilization, management of information and knowledge, and surveillance, monitoring and evaluation. Information, surveillance, monitoring and evaluation of the situation of maternal and neonatal health, as well as health programs - are essential to the continuation and improvement of efforts to reducing maternal mortality. This should include national and subnational disaggregation. committees maternal and neonatal mortality are an experience to identify and investigate (audits) and maternal deaths, according to the findings and conclusions, recommend the necessary measures.

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