



Findings of the 2021 National Maternal Mortality

Presented by: Dr. Ali Arbaji

Senior Data Analyst Consultant/ USAID Health Services Quality Accelerator Activity

Date: Nov 23, 2022

Venue: Ministry of Health

Disclaimer

The contents in this presentation do not necessarily reflect the views of USAID or the United States Government.

Acknowledgement:

Jordan's Maternal Mortality Surveillance and Response System was made possible by the generous support of the American people through the United States Agency for International Development (USAID).



Jordan's Maternal Mortality Surveillance & Response System النظام الوطني للرصد والإستجابة لوفيات الأمهات

Reporting Period

The **descriptive analysis** in this presentation covers the reporting period from:

January 1st to December 31st 2021



Jordan's Maternal Mortality Surveillance & Response System

Jordan's Maternal Mortality Ratio 2021

• During the reporting period, 1,871 deaths occurred among Women at reproductive Age.

- A total of **160** deaths were identified as maternal.
- A total number of 187,722 live births occurred during the same period.

 Jordan's Maternal Mortality Ratio was calculated at: 85.2 per 100,000 live births.



Distribution of MMR and Non-COVID MMR by Year

Year	Number of Live Births	Total Number of Deaths	Non COVID-19 Deaths	MMR	Non COVID-19 MMR
2021	187,722	160	56	85.2	29.8
2020	176,557	68	53	38.5	30.0
2019	194,643	63	63	32.4	32.4
2018	207,917	62	62	29.8	29.8



Maternal Deaths by Demographic Characteristics

- Maternal Age Group
- Nationality
- Educational Level
- Employment Status
- Place of Residence and Place of Death

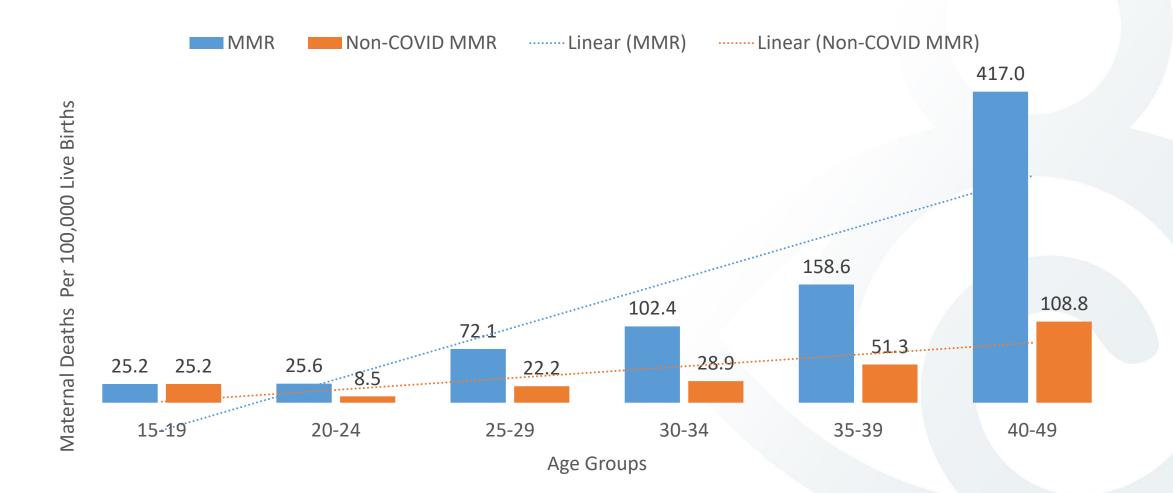


Distribution of Maternal Deaths by Age Group

Age Group	Number of Maternal Deaths	Percent
15-19	2	1.3
20-24	10	6.3
25-29	41	25.6
30-34	42	26.3
35-39	40	25.0
40-49	25	15.6
Total	160	100

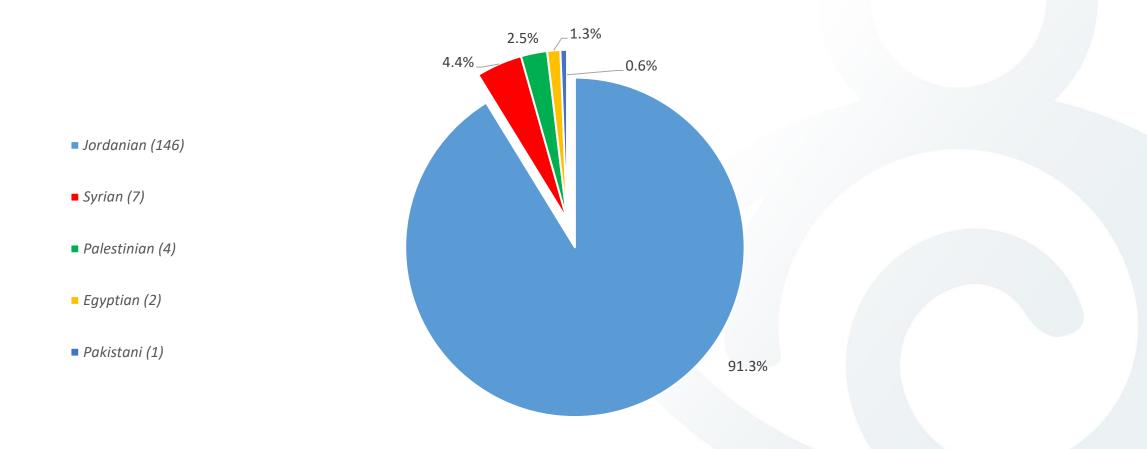


Distribution of MMR and Non-COVID MMR by Age Group for Jordanians





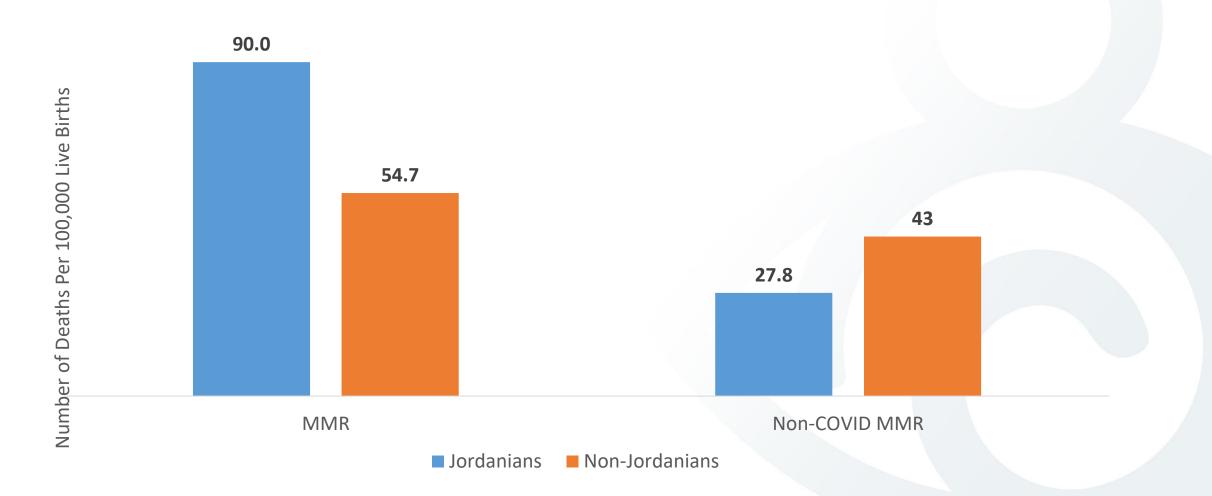
Maternal Deaths by Nationality





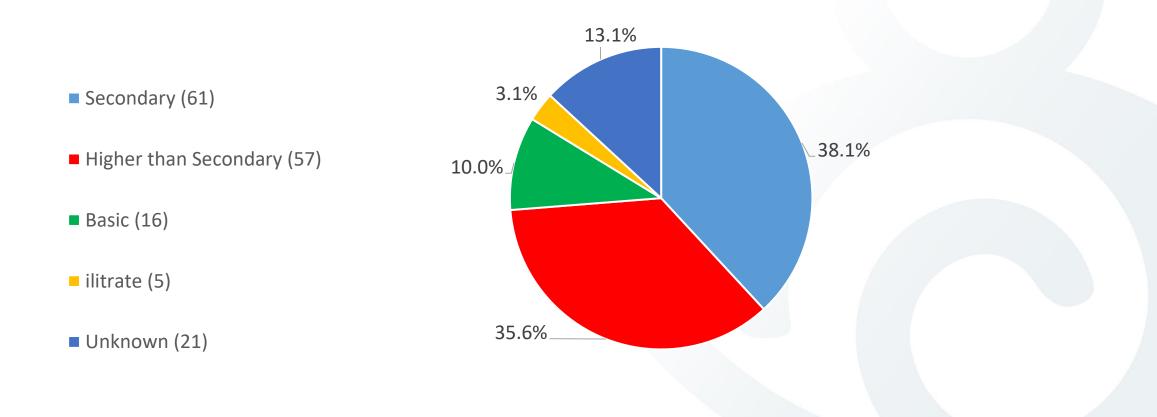
Jordan's Maternal Mortality Surveillance & Response System

Distribution of MMR and Non-COVID MMR by Nationality



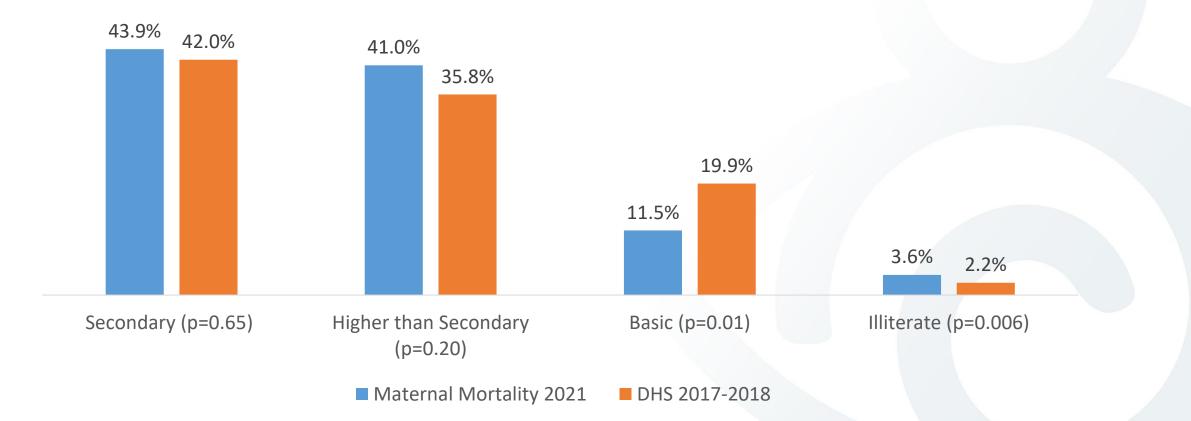


Maternal Deaths by Educational Level



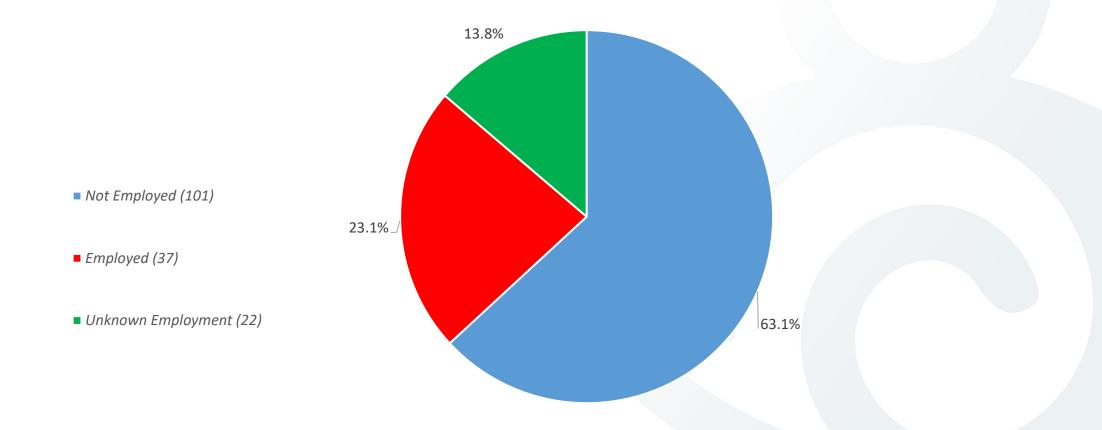


Comparison of Educational Level with DHS Data





Maternal Deaths by Employment Status





Distribution of COVID-19 According to Employment

COVID-19 Status	Employmo (Perc	Total	
	Not Employed	Employed	
COVID Deaths	62	27	89
	(61.4)	(73)	(64.5)
Non-COVID Deaths	39	10	49
	(38.6)	(27)	(35.5)
Total	101	37	138
	(100)	(100)	(100)



Maternal Deaths by Place of Death & Place of Residence

Covernerate	Place of Residence	Place of Death
Governorate	Number (Percent)	Number (Percent)
Ajloun	2 (1.3)	2 (1.3)
Amman	53 (33.1)	88 (55.0)
Aqaba	8 (5.0)	7 (4.4)
Balqa	11 (6.9)	6 (3.8)
Irbid	39 (24.4)	36 (22.5)
Jerash	2 (1.3)	0 (0)
Karak	3 (1.9)	2 (1.3)
Maan	2 (1.3)	1 (0.6)
Madaba	7 (4.4)	2 (1.3)
Mafraq	10 (6.3)	5 (3.1)
Tafilah	8 (5.0)	5 (3.1)
Zarqa	15 (9.4)	6 (3.8)
Total	160 (100.0)	160 (100.0)



Maternal Deaths Reported in Amman According to Place of Residence

Governorate	Place of Residence	Percent
Amman	53	60.2
Balqa	5	5.7
Irbid	4	4.6
Jarash	1	1.1
Karak	1	1.1
Maan	1	1.1
Madaba	5	5.7
Mafraq	5	5.7
Tafilah	4	4.6
Zarqa	9	10.2
Total	88	100



Distribution of MMR and Non-COVID MMR by Governorate of Residence

Governorate	Number of Live Births	Number of Maternal Deaths	Number of Non- COVID Deaths	MMR	Non-COVID MMR
Ajloun	5,285	2		37.8	-
Amman	78,298	53		67.7	-
Aqaba	4,462	8		179.3	-
Balqa	11,095	11		99.1	-
Irbid	34,021	39		114.6	-
Jerash	7,159	2		27.9	-
Karak	7,311	3	-	41.0	-
Maan	2,883	2	-	69.4	-
Madaba	5,192	7	-	134.8	-
Mafraq	11,686	10	-	85.6	-
Tafila	2,408	8	* 	332.2	-
Zarqa	17,922	15	*	83.7	-
Total	187,722	160		85.2	•

Figures in red are above the national value.



Maternal Deaths by Clinical Characteristics

- Parity
- Timing of Death
- Antenatal Care
- Mode of Delivery
- Fetal Outcome
- Anemia Status

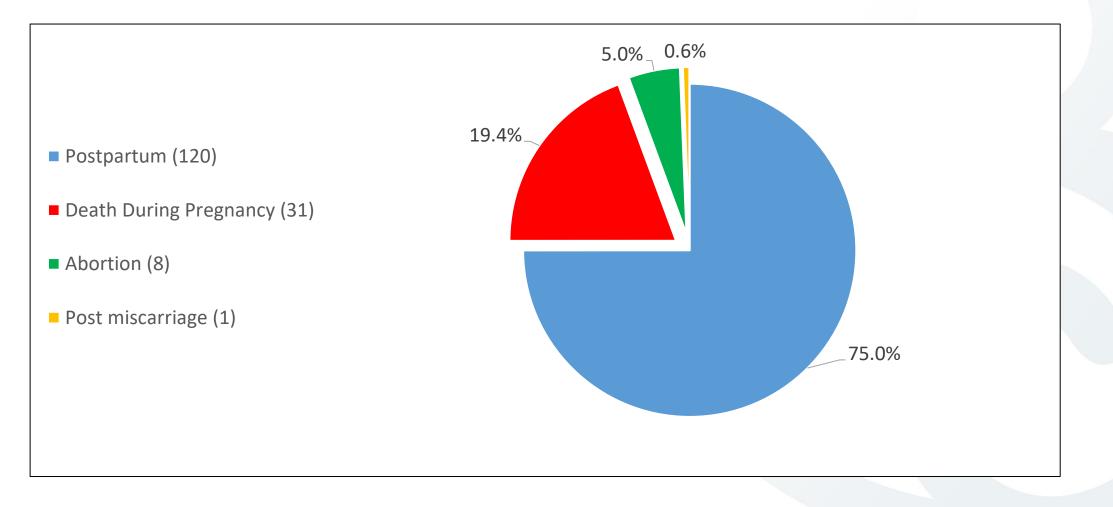


Maternal Deaths by Parity

Parity	Number of Maternal Deaths	Percent
Nulliparous (0 parity)	8	5.0
Para one	30	18.8
Multipara (2-4)	82	51.3
Grand Multipara (5-6)	31	19.4
Great grand multipara (≥7)	7	4.4
Unknown	2	1.25
Total	160	100



Maternal Deaths by Timing of Death





Jordan's Maternal Mortality Surveillance & Response System

Timing of Postpartum Maternal Deaths

Time of Death after Delivery	COVID Deaths	Non-COVID Deaths	Total
	(Percent)	(Percent)	(Percent)
Less than 24 hours	10	17	27
	(11.5)	(51.5)	(22.5)
Between 1 to 7 days	31	5	36
	(35.6)	(15.2)	(30)
Between 8 to 42 days	46	11	57
	(52.9)	(33.3)	(47.5)
Total	87	33	120
	(100)	(100)	(100)



Maternal Deaths by Number of Antenatal Care Visits

Antenatal Care Visits	Number of Maternal Deaths	Percent	Percent Out of Known ANC Visits
No Antenatal Visits	1	0.6	0.8
1-3 Visits	21	13.1	16.4
4-7 Visits	81	50.6	63.3
≥8 Visits	25	15.6	19.5
Unknown	32	20.0	-
Total	160	100	100



Maternal Deaths by Place of Antenatal Care

Place of Antenatal Care Visits	Number of Maternal Deaths	Percent	Percent Out of Known ANC Visits
Private Sector	85	53.1	63.0
Public Sector	45	28.1	33.3
Mixed Public/Private	5	3.1	3.7
No ANC or Unknown	25	15.6	-
Total	160	100	100



Maternal Deaths by Provider of Antenatal Care

Provider of Antenatal Care	Number of Maternal Deaths	Percent	Percent Out of Known ANC Visits
Doctor	124	77.5	91.9
Doctor + Midwife	9	5.6	6.7
Midwife	2	1.3	1.5
Unknown	25	15.6	-
Total	160	100	100

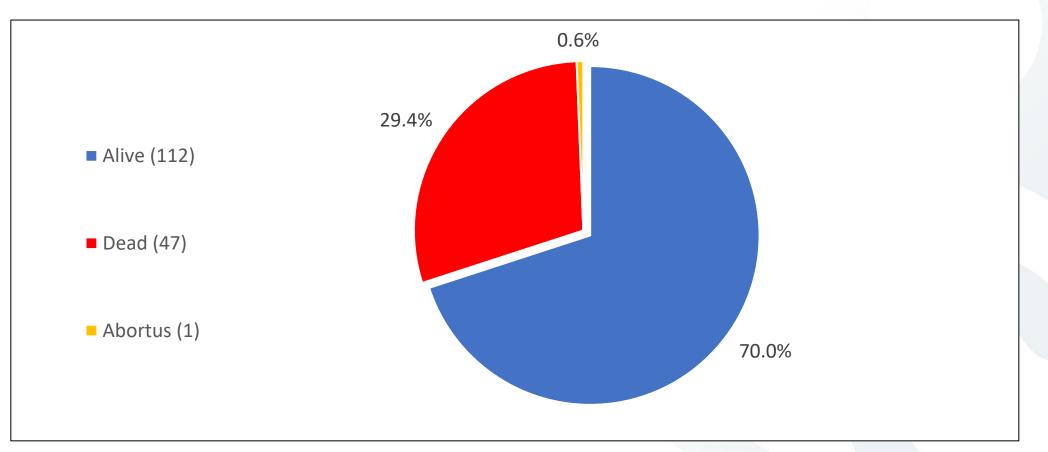


Maternal Deaths by Mode of Delivery

Mode of Delivery	Number of Maternal Deaths	Percent	Percent of Deliveries				
Cesarean Section	109	68.1	84.5				
Emergency Cesarean	93	58.1	72.1				
Elective Cesarean	9	5.6	7.0				
Postmortem Cesarean	7	4.4	5.4				
Vaginal Delivery	19	11.9	14.7				
Miscarriage	11	6.9	-				
Forceps	1	0.6	0.8				
No Delivery	20	12.5	-				
Total	160	100	100				



Maternal Deaths by Fetal Outcome





Jordan's Maternal Mortality Surveillance & Response System

Maternal Deaths by Anemia Status

Anemia Status	Number of Maternal Deaths	Percent	Percent of Known Hb Values			
No-Anemia	69	43.1	46.9			
Mild	49	30.6	33.3			
Moderate	28	19.0				
Severe	1	0.6	0.7			
Arrived Dead	13	8.1	-			
Total	160	100	100			



Causes of Maternal Death

- Of the 160 maternal deaths, the NAG assigned the main cause of death to 158 cases.
- NAG used the International Classification of Diseases (ICD 10) in assigning type, group and underlying cause of death.
- Autopsy was performed in about 19% of all deaths and about 52% of non-COVID deaths.



Distribution of Autopsy by COVID Cause of Death

Autopsy Performed		COVID-19 Being Cause of Death (Percent)							
	Yes	No							
Yes	1	29	30						
	(0.96)	(51.8)	(18.8)						
Νο	103	27	130						
	(99.04)	(48.2)	(81.2)						
Total	104	56	160						
	(100)	(100)	(100)						



Underlying Causes of Maternal Death

Cause of Death	Number	Percent	Percent of Non-COVID



Causes of Maternal Death (Continued)

Cause of Death	Number	Percent	Percent of Non- COVID
Antepartum Hemorrhage	1	0.6	1.8
Cardiomyopathy	1	0.6	1.8
Cerebrovascular Infarction	1	0.6	1.8
Diabetic Ketoacidosis	1	0.6	1.8
Encephalitis	1	0.6	1.8
Fatty Liver	1	0.6	1.8
Intestinal Obstruction	1	0.6	1.8
Intracerebral Hemorrhage	1	0.6	1.8
Metastatic Rectal Carcinoma	1	0.6	1.8
Myocarditis	1	0.6	1.8
Peripartum Cardiomyopathy	1	0.6	1.8



Causes of Maternal Death (Continued)

Cause of Death	Number	Percent	Percent of Non- COVID
Raptured Aortic Aneurysm	1	0.6	1.8
Raptured Splenic Aneurysm	1	0.6	1.8
Sagittal Sinus Thrombosis	1	0.6	1.8
Subdural Hemorrhage	1	0.6	1.8
Unspecified	2	1.3	3.6
Total	160	100	-
Total Non-COVID	56	-	100



Direct Causes of Maternal Death

Di	rect Cause of Death	Number	Percent	Non- COVID Percent
Subtotal		34	21.3	60.7



Indirect Causes of Maternal Death

Indirect Causes of Death	#	%	Non-COVID %
Disease of respiratory system (COVID and Pneumonia)	107	66.9	5.4
Diseases of the circulatory system (<i>MI, cardiomyopathy, myocarditis, rupture aortic and splenic aneurysms</i>)	7	4.4	12.5
Diseases of the central nervous system (cerebrovascular infarction, encephalitis and brain hemorrhage)	4	2.5	7.1
Diseases of the digestive system (intestinal obstruction and fatty liver)	2	1.3	3.6
Other maternal diseases (Septic shock)	2	1.3	3.6
Endocrine, nutritional and metabolic diseases (diabetic ketoacidosis)	1	0.6	1.8
Neoplasms (metastatic rectal carcinoma)	1	0.6	1.8
Subtotal	124	77.5	35.7
Unspecified	2	1.3	3.6
Total	160	100	100



Avoidability of Death by All Direct and Indirect Causes

Avoidability	Direct Cause (Percent)	Indirect Cause (Percent)	Unspecified (Percent)	Total	Percent		
Yes	27 (79.4)	22 (17.7)	0 (0)	49	30.6		
No	7 (21.6)	102 (82.3)	0 (0)	109	68.1		
Unspecified	0 (0)	0 (0)	2 (100)	2	1.3		
Total	34 (100)	124 (100)	2 (100)	160	100.0		



Maternal Deaths by Level of Delay for All Deaths

Level of Delay	Number	Percent
Delay in Seeking Care: Delay I	18	11.3
Delay in Receiving Care: Delay III	25	15.6
Delay in Seeking and Receiving Care: Delays I&III	5	3.1
Delay in Seeking, Reaching and Receiving Care: Delays I+II	1	0.6
No Delay	109	68.1
Unspecified	2	1.3
Total	160	100



Maternal Deaths by Level of Delay for Non-COVID Deaths

Level of Delay	Number	Percent
Delay in Seeking Care: Delay I	7	12.5
Delay in Receiving Care: Delay III	23	41.1
Delay in Seeking and Receiving Care: Delays I&III	5	8.9
Delay in Seeking, Reaching and Receiving Care: Delays I+II	1	1.8
No Delay	18	32.1
Unspecified	2	3.6
Total	56	100



Summary of Findings

- MMR of 85.2 vs non-COVID MMR or 29.8 per 100k of live births
- MMR increased with age
- MMR varied by governorate
- About 61% of non-COVID deaths were direct
- Obstetric hemorrhage was the most common cause of direct death
- Obstetric embolism was the second common cause of direct death
- Over **79%** of direct deaths were considered preventable deaths
- About **52%** of non-COVID deaths underwent autopsy
- About **50%** of non-COVID deaths suffered from delay in receiving care
- COVID vaccination among pregnant women was too low



Recommendations

- Almost all the proposed recommendations in 2020 maternal mortality report have never been acted upon.
- This section largely repeats the recommendation of 2020, hoping that all stakeholders will work jointly to implement the proposed responses under the MOH stewardship.



Recommendations

- Enhance the Quality of Emergency Obstetric Care
- Strengthen Jordan's COVID-19 Response in Obstetrics
- Supporting Vaginal Births and Reducing Unnecessary Primary CS Deliveries
- Adopting Strategies for the Quality ANC including High-Risk Pregnancy Management at primary and secondary care level
- Increase the uptake of quality family planning methods







Thank You!

Disclaimer

The contents in this presentation do not necessarily reflect the views of USAID or the United States Government.

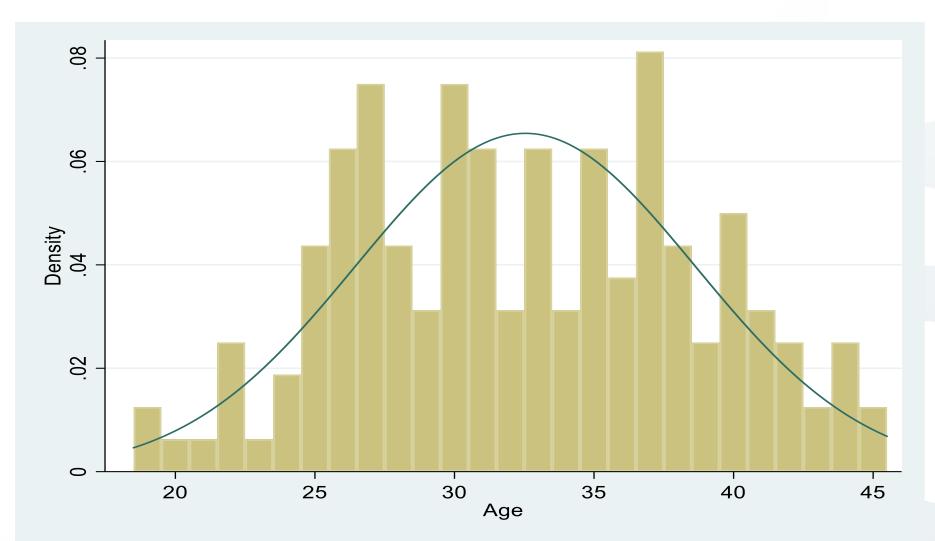
Acknowledgement:

Jordan's Maternal Mortality Surveillance and Response System (JMMSR) was made possible by the generous support of the American people through the United States Agency for International Development (USAID).



Jordan's Maternal Mortality Surveillance & Response System النظام الوطني للرصد والإستجابة لوفيات الأمهات

Age Density Function





Jordan's Maternal Mortality Surveillance & Response System