

## Delivering maternal health

### Why is Rwanda doing better than Malawi, Niger and Uganda?

**S**afe motherhood is a key objective for developing countries but, despite recent improvements, sub-Saharan Africa is still the most dangerous place in the world to give birth. This Briefing Paper uses new research by the Africa Power and Politics Programme (APPP) to explore the factors that shape maternal health outcomes in Malawi, Niger, Rwanda and Uganda. It examines the institutional causes of bottlenecks in the provision of maternal health services and considers the policy implications for country actors and donors.



High numbers of expectant mothers are attending pre-natal consultations in Rwanda.

#### Key points

- The causes of maternal death are known and mostly preventable
- Rwanda has overcome key obstacles to the delivery of adequate and appropriate maternal health services
- Institutional solutions are needed to improve maternal health, including policy coherence, enforced performance standards and local problem solving

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#### Main causes of maternal death

Improving maternal health is a global priority: the fifth Millennium Development Goal commits countries to reducing maternal mortality by three-quarters by 2015. However, inadequate access to appropriate health care means many women still do not survive pregnancy and childbirth. This is most visible in sub-Saharan Africa, where the overwhelming majority of the world's maternal deaths take place. But continent-wide figures hide disparities within and between countries and, while the general trend is poor, some countries provide a beacon of hope.

There is consensus that most of the main causes of death during and following pregnancy and childbirth – severe bleeding (post-partum haemorrhage), infections (sepsis), high blood pressure, obstructed labour and unsafe abortions – are preventable or manageable (World Health Organization, 2004). Antenatal care during pregnancy and the attendance of skilled professionals during and after childbirth reduce the risk associated with these complications. Access to family planning services to prevent unwanted pregnancies is also essential (WHO, 2007).

However, there are common obstacles to the effective delivery of these key elements in Africa.

These obstacles act as bottlenecks to better provision and are particularly acute in rural settings. Three particular types stand out:

- **Delays in seeking health care:** Women or their families are often slow to seek medical assistance. Obstacles to timely diagnosis and treatment include suspicion or ignorance of modern health services, prohibitive financial costs and weak incentives to use public health facilities.
- **Transfer delays:** The lengthy time it takes to refer and transfer women to health facilities with the required technical capacity means emergency interventions come late. Obstacles include lack of accessible health infrastructure and failings in emergency evacuation procedures, such as ambulance services.
- **Shortcomings in the quality of care:** Even when women reach appropriate health facilities, the quality of care available can hamper the treatment of complications. Obstacles include shortage of appropriately trained health staff, stock-outs of blood and medicine, poor staff motivation and low adherence to professional standards.

The obstacles that contribute to these bottlenecks must be overcome if maternal health outcomes are to improve.

### Similar conditions, uneven progress

Malawi, Niger, Rwanda and Uganda differ in many respects but share conditions of general resource scarcity and all rely heavily on external resources to finance public health care. They have followed similar approaches to health financing. All experimented with cost recovery in the 1990s and now favoured some form of user fee exemption. All have also implemented decentralisation measures to devolve health service delivery to the local level.

However, progress on national maternal health indicators over the past 20 years has been uneven. Maternal mortality ratios for Malawi and particularly Rwanda have fallen consistently since 2000 (Figure 1). In Malawi, however, the gains barely recover the losses sustained during the 1990s. Uganda registered only a modest decrease between the last two surveys and Niger almost none. Likewise, the number of women giving birth at health facilities in these two countries registered only small or negligible percentage increases. Malawi made substantial progress on this indicator from the mid-2000s, but Rwanda saw the most spectacular improvement: an increase from 28% in 2005 to 69% in 2010.

Trends in real health expenditure per capita indicate a relationship between spending and health outcomes. However, Figure 2 shows that the greatest increase in per capita health expenditure has taken place in Uganda – where outcomes have improved little. And outcomes remain unchanged in Niger despite health spending doubling (albeit from a very low level) between 2004 and 2009. Although expenditure is clearly part of the story, it is not the whole story.

### Tackling the obstacles to service provision

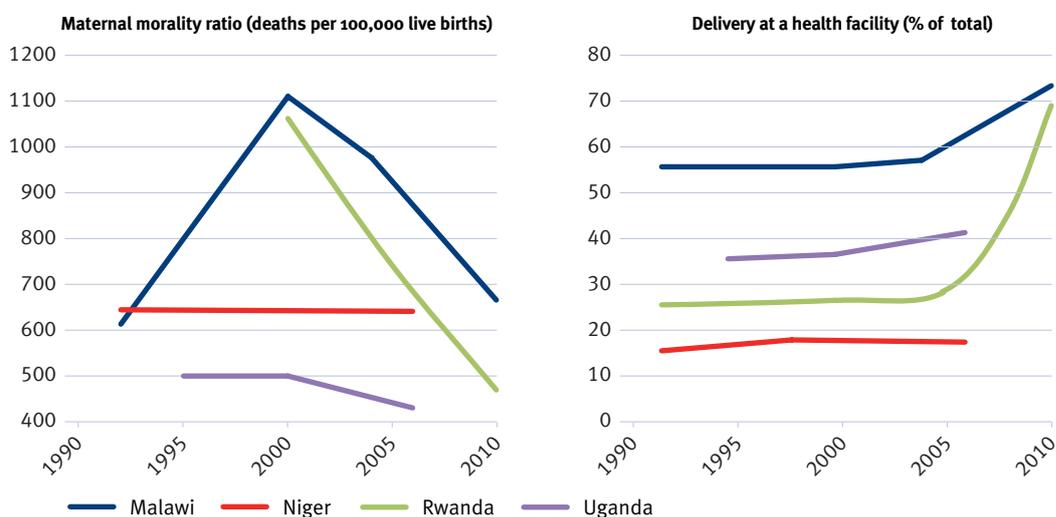
APPP field studies (Cammack, 2012; Chambers and Golooba-Mutebi, 2012; Golooba-Mutebi, 2011; Olivier de Sardan, 2012) draw attention to the extent to which the particular bottlenecks in service provision described above have been addressed in specific contexts. These differences begin to explain why Rwanda is reducing maternal mortality rates more rapidly than Malawi, Niger and Uganda. Selected examples from the case studies illustrate this point.

#### Use of modern services

The cross-country differences in knowledge of, and incentives to use, modern medical assistance are substantial. In Rwanda, the fast-improving uptake of maternal health services, including family planning and antenatal care as well as health centre deliveries, appears to be a response to, among other things, a very effective public education campaign on the importance of these activities for mother and child health. This has been supported by a system of fines imposed on women who fail to attend antenatal care and deliver in health care centres. Survey data suggest Malawi has made progress in some of these areas too.

In Uganda, on the other hand, use of maternal health services appears much more nominal, with little evidence of behavioural change. Traditional birth attendants are banned in all four countries, but they remain popular with local populations in Malawi, Niger and Uganda. Only in Rwanda, where they were integrated into and subsequently replaced by the village community health system, have they effectively disappeared.

Figure 1: Selected maternal health indicators



Source: Computed from Demographic and Health Survey data, various years.

### Timely transfers

The feasibility of timely transfers to higher-level facilities for emergency interventions, such as caesarean sections, appears to differ markedly across the countries. This bottleneck has remained severe in Niger and a significant challenge in Uganda. Health centres in Niger have ambulances at their disposal but patients have to pay for fuel and cover other expenses, which often makes immediate evacuation impossible.

In Rwanda, physical distances are typically less than in Niger but transport challenges are not insignificant. The barriers have reduced significantly thanks to widespread adherence to a community health insurance scheme which covers 90% of the cost of ambulance transfers. Voluntary community health workers (CHWs) have been issued with specially programmed mobile phones so they can contact health facilities for referral. Also, the increasing availability of ‘waiting wards’ for expectant mothers at rural Rwandan health centres makes accidental home births less likely and enables the swift diagnosis of complicated deliveries.

### Better quality care

Finally, service quality in local health facilities differs across the four countries. In Rwanda, basic obstacles in this regard seem to have been addressed: health centre opening hours are respected; levels of hygiene appear good; and staff are generally respectful towards patients. Monitoring and supervision visits by superior authorities (hospitals) actually take place. CHWs have been trained extensively and are provided with incentives to reach maternal and child health targets.

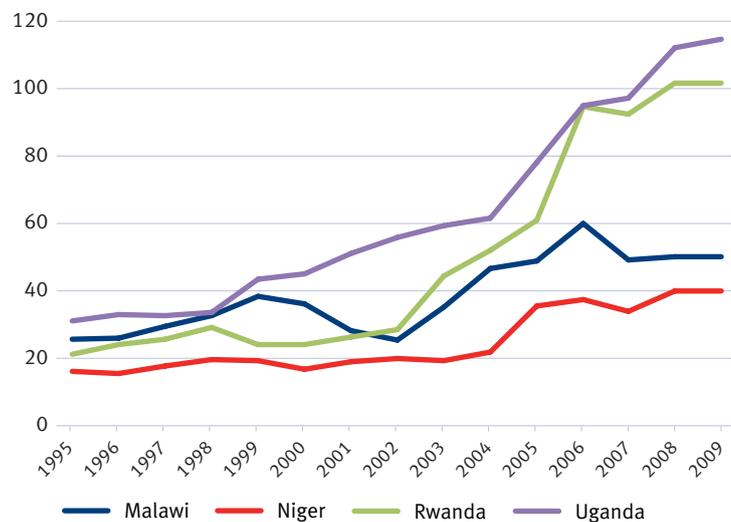
By contrast, even in the relatively favoured Ugandan southwest, health centres suffer from high levels of absenteeism and opening hours are rarely respected. Local level fieldwork in Malawi, Niger and Uganda found that staff attitudes towards patients are often demeaning. Unable to absorb the increased numbers of women giving birth in health centres, facilities in Malawi and Uganda have suffered from severe overcrowding, overwhelming the capacity of frustrated staff. Lack of incentives in both countries has led many public sector staff to open private facilities, often while moonlighting from their public positions.

### Institutional explanations

The factors described above go some way to explaining the pattern of outcomes across the four countries. But they also invite further questions. Why have these typical bottlenecks been addressed in some countries and not others?

The APPP research points to the importance of three variable features of the institutional arrangements governing maternal health. First, the extent to which *policy processes* deliver internally coherent policies. Second, whether or not provider

**Figure 2: Health expenditure per capita, PPP (constant 2005 international \$)**



Source: Computed from World Development Indicators.

*performance disciplines* are enforced, so professional standards are upheld. Third, the extent to which local *problem-solving initiatives*, capable of overcoming key bottlenecks, are tolerated or encouraged.

### Policy coherence

Across the four countries, policy processes are very uneven in terms of whether they deliver a coherent policy environment for maternal health. In Niger, an overnight presidential decision to abolish user fees for pregnant women and under-fives in 2006 nearly resulted in the collapse of the health system. The reform was implemented without the necessary accompanying measures: increased demand and delayed payments by the state triggered severe cash-flow problems for primary health units, eventually leading to critical shortages of medicines.

In contrast, policy reforms in Rwanda have been mutually reinforcing. The use of voluntary CHWs alongside strong encouragement to subscribe to the nationwide health insurance scheme has been critical to local uptake of maternal health services. And government-led sector-wide planning has ensured donor support plugs real resource gaps.

### Performance disciplines

The level of enforcement of professional performance disciplines, related to the presence or absence of strong upward accountability mechanisms, explains much of the difference in intermediate outcomes across the countries. Rwanda combines regular supervision with results-based health financing, alongside moral rewards and sanctions under the *imihigo* system of performance targets where local officials pledge publicly to achieve certain objectives. This system includes local officials with health responsibilities as well as health professionals. Public sector workers are forbidden to run private health care facilities.



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In Uganda, largely unsupervised health workers are prone to absenteeism, partly because there are no restrictions on their operating private clinics and shops. Misappropriation of medicines and irregular payments are commonplace because there is no active technical oversight and no system of professional performance incentives.

### Local problem-solving initiatives

Locally coordinated actions to address delivery bottlenecks are present in some contexts in all four countries. However, there are differences in how these local problem-solving initiatives relate to national policy processes.

The ‘extra pennies’ initiative in Niger is an example of the state hindering an effective local initiative. To address the bottleneck of emergency transfers, health sector actors in one district levied a small charge on all service users to create a fund to pay for ambulance drivers and fuel. The initiative worked well and spread rapidly to other districts, becoming semi-institutionalised. Eventually, the Ministry of Health banned it as contrary to the national policy on exemption from user charges, but without offering an alternative solution to the ambulance problem. This episode illustrates both the potential for effective problem solving and the rigidity of Niger’s national policy process.

Surprisingly, given the country’s reputation for authoritarianism, Rwanda provides the best example of the institutionalisation of local problem solving. The state facilitates local participatory problem-identification and action – *Ubudehe mu kurwanya ubukene*, or ‘collective action against poverty’ – and provides mechanisms for feeding lesson-learning back into policy.

## Policy implications

Maternal health outcomes will not improve quickly in low-income Africa as long as the known bottlenecks in public provision are not addressed. Improving the flow of resources will help, but not enough and not on its own. The similarities and differences between Malawi, Niger, Rwanda and Uganda point to the importance of three types of institutional factor in shaping outcomes. This indicates clearly enough what governments and development partners need to be doing if they are serious about improving maternal health:

- The whole set of policies bearing on maternal health outcomes needs to be reviewed regularly to ensure it is internally coherent.
- Provider performance standards need to be enforced, with appropriate upward accountability and monitoring.
- Where local solutions to major bottlenecks are found, they should be supported, not discouraged.

Obvious as they may appear, these prescriptions are notable by their absence in the majority of cases covered by the APPP research.

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