



Submission from: Professor Wendy J Graham, Mr David Braunholtz, Mr Alec Cumming, Dr Tim Ensor, Ms Sue Fairburn, Dr Julia Hussein (all of University of Aberdeen), Dr Eddie Addai, Ghana Ministry of Health and Dr Sam Adjei, Ghana Health Service; on behalf of Immpact

1. Key messages:

- **The burden of maternal mortality is borne disproportionately by the poor;**
- **Financial barriers to skilled delivery and emergency care are major reasons for this inequity;**
- **A window of opportunity has opened for reducing these barriers by abolishing user fees;**
- **Enabling governments to reduce these barriers is an evidence-based way to catalyse progress towards MDG5.**

What needs to be done is clear: the poorest women must have access to timely and effective care, particularly in the event of obstetric emergencies. A focus on the poor and on the reduction of financial barriers to skilled care can act as a hub for efforts, but with many wider spin-offs and benefits.

We set out below further material from Immpact in support of our key messages, and in response to specific questions posed by the Select Committee.

2. Background

Our 'key messages' emerge from Immpact research and are also supported by other sources of evidence.

Immpact is an international research initiative for **maternal mortality programme assessment**. It was set up in 2002 to improve the evidence-base for decision makers on cost-effective strategies to reduce maternal mortality.

Immpact developed innovative means to conduct programme evaluations; used these to assess maternal mortality reduction strategies in Burkina Faso, Ghana and Indonesia; and built capacity in these countries to gather and use evidence for decision-making.

Investment in Immpact was in direct response to donor and country concern about slow progress towards MDG5. There was recognition that gaps in evidence on effective strategies were significant bottlenecks. DFID played a crucial role in catalysing and sustaining Immpact. Many other research and programme initiatives in recent years have also contributed to strengthening the evidence base.

In our view, the bottlenecks have now shifted to communicating and acting upon the evidence, at country and international levels. In particular, the four¹ new major global enterprises relevant to MDG5 must make use of the available evidence in order to progress towards action.

¹ International Health Partnership; Women and Children First; Catalytic Initiative to Save a Million Lives; Innovative Result-based Finance.

3. Question: How can donors – and DFID specifically – catalyse progress towards MDG-5?

We urge DFID and other donors to champion explicitly the needs of the poorest women by focusing on the removal of financial barriers to delivery and emergency care, and so catalyse wider improvements in the demand and supply side of health systems in low-income countries.

We base our case around 4 key messages.

3.1 Message 1: The burden of maternal mortality is borne disproportionately by the poor.

An equity lens is essential to monitoring all indicators relevant to maternal health.

The poor-rich gap has been clearly demonstrated in many studies (Figure 1).

In relation to maternal mortality the gap is a reflection of wider inequities: in education, gender, and nutrition, for instance, and particularly in access to care. Poor women have limited access to care, especially for obstetric emergencies.

The lifetime risk of maternal death for poor women is further increased by the markedly higher fertility rates for women in the lowest income quintile in developing countries – these rates are typically 2-3 times higher than for women in the highest income quintile.

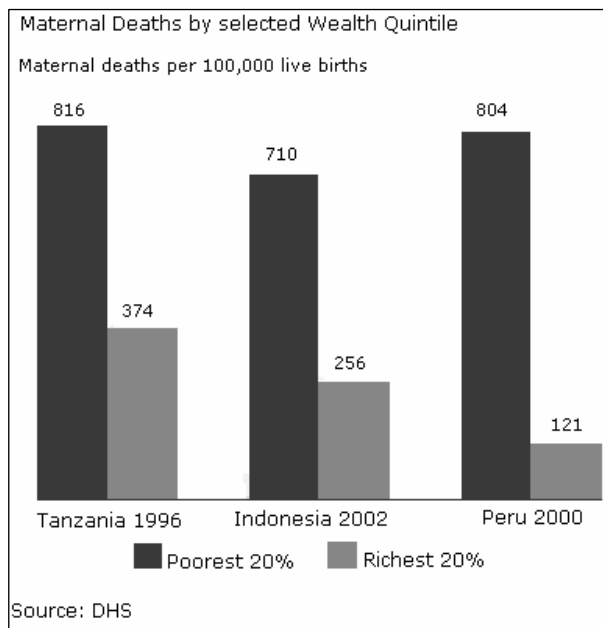
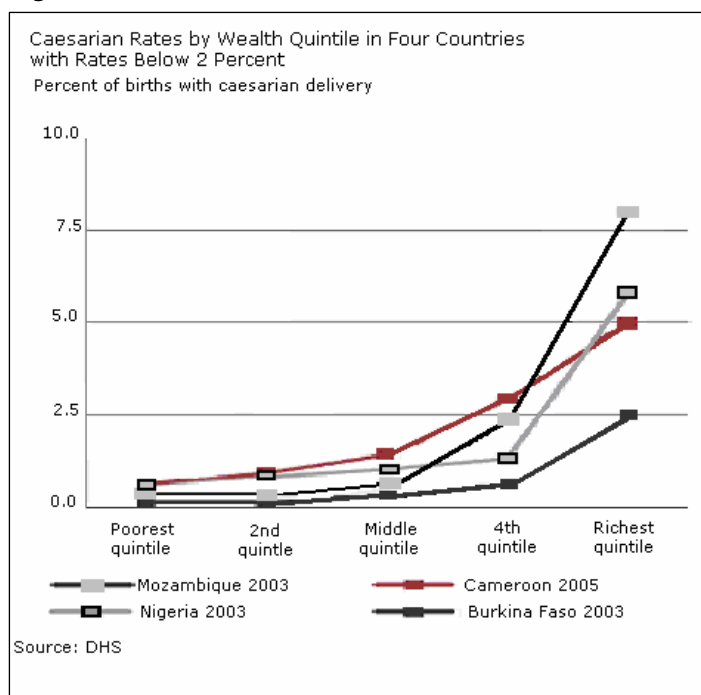


Figure 1

Figure 2



The disproportionate burden on the poor has not been adequately revealed or communicated, in part owing to data constraints and use of insensitive indicators.

We know, for example, that uptake of antenatal and delivery care with a health professional shows 2-6 fold differences between the rich and the poor. It is only recently that the gap for caesarean sections - a life-saving surgical intervention, was shown to be substantially greater in many low-income countries (Figure 2).

The burden does not stop at the death of a mother.

Young children lose the parent who makes the biggest difference to their survival and well-being (Figure 3).

Families disintegrate with the loss of the key person who feeds and cares for members. Societies and economies lose women in their prime of life and when most productive.

Better indicators are needed to quantify and communicate these broader aspects of the burden of mortality. Immpact, for example, is working on ways to estimate the number of children who lose their mothers during childbirth or whilst they are still young (*Motherhood Method*).

Figure 3

A study in Indonesia of over 2,500 children aged 6-10 showed that maternally orphaned children are approximately four times more likely to die compared to non-bereaved children, and twice as likely to drop out of school.

Source: id21 Insights 2007; 11:4

3.2 Message 2: Financial barriers to skilled delivery and emergency care are major reasons for the disproportionate burden of maternal mortality borne by the poor.

Even with existing knowledge gaps regarding the true burden from maternal mortality, it is clear that the costs of care help explain the wide and widening poor-rich gap.

Surgical interventions related to pregnancy and childbirth, especially caesarean sections, are amongst the most common and expensive operative procedures that families face. The costs of complicated deliveries are often “catastrophic” - a term used where costs are in excess of 10% of yearly household income. The consequences for the poorest groups are particularly devastating (Figure 4), plunging them further into irrecoverable debt.

Figure 4

In Burkina Faso on average, a normal delivery costs US\$39, rising to US\$124 for a caesarean section, and with transport costs to reach health facilities in addition. Delivery costs are estimated to constitute 43% of per capita income in the poorest households and as much as 138% for a caesarian section.

Source: Immpact

For women who survived obstetric complications, Immpact’s anthropological research in Burkina Faso and Indonesia also found adverse social consequences (Figure 5) arising from the costs of care.

Social tensions arising from catastrophic payments were felt very strongly in women’s daily lives according to research in Burkina Faso and Indonesia. These tensions were reflected in women’s efforts to cut back on their own spending to avoid being blamed for being ‘too expensive’, increased work activities to replenish depleted funds - even when they were still unwell, and increased perceived dependency and guilt. In some cases marital or other social relationships disintegrated as a direct result of the financial burden of emergency care.

Figure 5

3.3 Message 3: A window of opportunity has opened for reducing these barriers by abolishing user fees.

The universally adverse effect of user fees on the poor is now widely accepted. Many countries, particularly in sub-Saharan Africa, are taking the bold move to abolish fees. There is now a “head of steam” behind such a move, and many agencies - including DFID, are endorsing this. Advocates for maternal health should take special advantage of such an opportunity.

Our research provides evidence to support removal of fees for delivery and emergency obstetric care. But benefits in terms of reduced mortality will not be realised unless two further barriers are addressed – out of pocket expenses and poor quality of care.

Care made “free” at the point of service may still not reach the poorest women. Out-of-pocket expenses are still significant obstacles, including costs of transport, food, drugs and supplies, and informal charges. In Ghana, for example, although the Government’s fee exemption policy was shown by Immpact to have increased overall uptake of delivery care in health facilities (Figure 6), the fall in out-of-pocket payments was only 14% for the poorest households but almost double this for the richest. In other words, special consideration needs to be given to the equity dimension of free care.

Figure 6

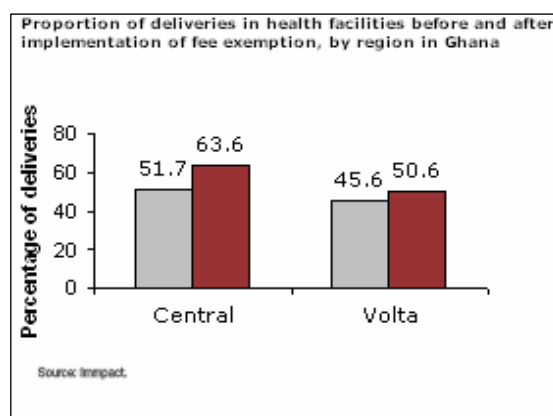


Figure 7

In Indonesia, women covered by the Government’s social insurance for the poor still had the lowest uptake of delivery with a health professional (<21%) and the highest level of mortality (630 maternal deaths per 100,000 live births). This compares with the equivalent figures of 31% and 410 for women without any insurance, and 81% and 235 for those with other insurance.

Source: Immpact

It is often assumed that financing schemes to reduce barriers to care will automatically be of greatest benefit to the poor.

Our research shows that, particularly for obstetric emergencies, free care without transport subsidies (as in Ghana) or social insurance for the poor without tackling referral costs (as in Indonesia), will undermine prospects for reducing maternal mortality (Figure 7).

The second additional barrier is poor quality of care.

Increased workload facing health professionals is a threat to the effectiveness of fee removal, with implications for staff motivation and quality of care.

These problems are particularly acute where there is already a massive shortage of skilled health professionals and functioning facilities (Figure 8).

Figure 8

In Burkina Faso, for example, the community mobilisation component of an intervention to increase uptake of institutional delivery helped to explain the increase in uptake observed by Immpact, over time and in comparison with a control district. However, improvements in the supply of care were constrained by the lack of facilities: 77% of births within 1 km of the health centre took place in a facility, compared to just 19% for births further than 10 km from the health centre. Access to life-saving interventions remained extremely low in the intervention area, with only 0.4% of all births being delivered by caesarean section. It is generally accepted that caesarean section rates of less than 1% indicate an unmet need for life-saving care.

Source: Immpact

3.4 Message 4: Enabling Governments to reduce financial barriers to delivery and emergency care is an evidence-based way to catalyse progress towards MDG5.

There is now an enabling international environment to push forward a concerted effort to do what needs to be done: the poorest women must have access to timely and effective care, particularly in the event of obstetric emergencies.

A focus on the poor and on the reduction of financial barriers to care can act as a hub for efforts, but with many wider spin-offs and benefits for the health system and for other health problems in low-income settings.

The way to achieve this cannot be a “one-size-fits-all” approach. The options and phasing for removing financial barriers need to be context-specific, and built into national plans. These plans are now being called for by the four² new major global actions relevant to MDG5. The Innovative Result-based Financing, for example, can provide a stimulus for tackling financial barriers to delivery and emergency obstetric care, with equity-sensitive indicators used to track progress.

It is important that these plans also mobilise interim funds whilst Governments seek to establish mechanisms for replenishing income lost from the abolition of user fees.

Impact is now using evidence to help design strategic alternatives for reducing financial barriers in specific country contexts. We refer to these as **FreeD** strategies - a term which captures the primary aim - for women to be freed from the financial barriers to delivery and emergency care.

We urge DFID and other donors to prioritise FreeD strategies within and through the new international initiatives to catalyse progress towards MDG5.

4. Question: How effectively DFID is working with recipient countries to resolve EmOC and HR issues?

We sought a view on this from a senior colleague who was attached to the project for a year but who previously had been Deputy Director-General of the Ghana Health Service. The response is based in part on Impact experience and in part on his and colleagues experience within the Ghana Health Service and Ghana Ministry of Health. The full report is included as an appendix, but the key messages in response to this question are: -

- 1) DFID has contributed about £7-10m annually to the programmes of work agreed with the Ghana Ministry of Health through flexible funding arrangements for the sector. However the release of funds has been unpredictable and erratic in recent times.
- 2) DFID closed its health office in Ghana without discussion. This has created a vacuum in the policy dialogue in Ghana. It has also deprived the health sector of good quality technical support in health as a whole and in dealing with MDG5 in particular.
- 3) DFID and other donors can support Ghana’s effort at achieving MDG5 by:
 - i) Providing more flexible funding especially as they move into multi-donor support
 - ii) Providing technical support for policy, human resource development, evaluation and research
 - iii) DFID especially can assist in exchange programs with NHS UK in service delivery support and training of skilled personnel
 - iv) DFID needs to revisit its policy of closing down its country office for health.

5. Question: How achieving MDG5 is being prioritised and integrated into countries’ overall health provision?

Achievement of MDG5 is not simply a matter for Ministries of Health and health provision. The findings of our project are that education, nutrition, employment and transport all have major impacts on maternal health. The Public Services Agreement (PSA) approach by DFID in sub-Saharan Africa provides flexible funding where this is feasible, but the temptation to target resource through vertical initiatives, experienced by our Ghanaian colleagues, needs to be resisted by DFID and as far as DFID can influence them, by other donors.

² International Health Partnership; Women and Children First; Catalytic Initiative to Save a Million Lives; Innovative Result-based Finance.

6. Question: How effectively DFID works with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health?

DFID have provided very effective leadership through the substantial contribution of Dr Stewart Tyson as Chair of the group of Funders for this project which is an example of donors (the Bill and Melinda Gates Foundation, USAID and DFID) working together for maternal health.

We do observe, however, in working with DFID colleagues both in the UK and in developing countries that they are frequently overstretched by the volume and range of work they must undertake, so that their potential for providing leadership and influence cannot always be realised. The experience of our colleagues in Ghana where DFID interests are looked after by another national agency, demonstrates the dangers of this overstretch.

7. Question: What leadership the UN is providing and how well coordinated its agencies are?

In our experience and opinion this has, and continues to be, a problematic issue for maternal health. The absence of a clear and unequivocal technical lead agency for this important target group has resulted in tensions and duplication of efforts at country and international levels. By comparison, the example of UNICEF's lead for child health shows what can be gained within and beyond the UN family by such clarity of mandate. The recent creation of the Partnership for Maternal, Newborn and Child health (PMNCH), on which the Impact Principal Investigator sits as a Board Member, cannot be expected to provide leadership on maternal health, since its remit is the MNCH continuum. We understand that three agencies - WHO, UNICEF and UNFPA - are now being regarded as the triad of leaders within the UN. Our hope is that this succeeds, though history would suggest otherwise.

Appendices

- 1) Stopping Women dying during childbirth; how are the Commonwealth countries doing? (submission to Commonwealth govt conference, O. Campbell, W. Graham, Aug 07)
- 2) "Dear Minister" – an open letter to developing country ministers urging action on maternal health – Wendy graham and others, Reproductive Health Matters 2007; 15 (30)
- 3) Dying Mothers – from the evidence to political will – news article in Real Health News May 2007
- 4) Delivering Safer Motherhood –Sharing the Evidence – Policy Brief from Impact February 2007.
- 5) Comments for the Committee from Dr Sam Adjei, former Deputy Director-General of the Ghana health Service and Dr Eddie Addai, Director of Policy, Planning, Monitoring and Evaluation for the Ministry of Health, Ghana
