MILLENNIUM DEVELOPMENT GOAL 5
BACKGROUND NOTE

NOVEMBER SUMMIT 2008

Progress towards Millennium Development Goal 5 in Ghana

Where are we and where do we start from? Synthesis of recent material.

Introduction

For the November 2008 Health Summit Ghana the Health Sector Advisory Office (HSAO[1]) was tasked and with some input from the Summit Planning committee to summarise recent discussions pertaining to the reduction of maternal mortality.

Indicators for maternal health in Ghana have at best remained at the same level for the last decennium raising concerns about achieving Millennium Development Goal 5 (MDG 5). At the April 2008 Health Summit the Honourable Minister for Health Major (retired) Courage Quarsigah declared the Maternal Mortality Rate in Ghana unacceptably high and to be regarded by the Ministry of Health as a national emergency requiring immediate action. The theme for the November 2008 Health Summit clearly indicates the priority health sector partners have put on these issues to feed into the 2009 Programme of Work (POW). Not to revisit work already undertaken and decisions already made, this paper sets out to compile important outcomes of the process to improve progress towards MDG 5 as a starting point for discussions during the Health Summit that should lead to adopted and actionable elements in the POW 2009.

The presented course of action does not necessarily represent the opinion of HSAO or the Health Summit Planning Committee and is just distilled from existing documents [2,3].

[1] HSAO sets out to contribute to better informed decision making in the health sector in Ghana. It believes that validating the information input into the health sector policy dialogue between government and partner stakeholders will - given an enabling, conducive and creativity encouraging environment - improve the quality of debate and will therefore lead to more rational priority setting and decision making conforming to the ultimate goals of the agreed national health sector strategy.

[2] Grey literature available at HSAO

[3] Campbell, O. et al. Maternal Survival Series, Lancet 2006

Global situation

The United Nation's MDG 5 to improve maternal health stipulates two global targets:

1. Reduce maternal mortality ratio by 75% between 1990 and 2015
2. Universal coverage of skilled care at birth by 2015

Anno 2008 we can conclude that progress towards MDG 5 is globally off track - only half of the world's women are giving birth assisted by a skilled professional - with large equity gaps between the rural-urban, poor-rich and uneducated-educated population in developing countries and more specifically in Sub-Sahara Africa with stagnating maternal mortality indicators.

This paper has been structured according to two prevailing approaches for improvement of the situation:

1. Intra-partum care strategy
   - Skilled attendance at delivery
   - Emergency obstetric care
2. Complementary strategies
   - Antenatal Care
   - Family Planning
   - Adolescent reproductive health
   - Safe abortion

The problems of infant and maternal mortality are inherently complex. Despite this complexity, only a few strategic choices need to be made to reduce maternal mortality. Most maternal deaths occur during labour, delivery, or the first 24 hours postpartum, and most complications cannot be predicted or prevented. The location of women **when they deliver, who is attending them, and** how quickly they can be transported to referral-level care are thus crucial factors in determining interventions that are needed and feasible.

Ghana

Translating MDG 5 for Ghana, a national target to reduce the Maternal Mortality Ratio (MMR) from 214 in 1990 to 54 by 2015 (MMR = maternal deaths per 100,000 live births) was set. However estimates for the current situation point at:

- An institutional (i.e. pregnant women delivering in the clinic) MMR around 210
- A total MMR estimated at 540 (WHO, 2006)

To guide the process of transforming situational knowledge into actionable interventions to be adopted at and by the different levels of the health system in Ghana, this paper will continue to discuss issues and actions identified in past forums structured along these lines. An added advantage of structuring the discussion in this way would be its congruency with the Marginal Budgeting for Bottlenecks (MBB) tool to evaluate intended scenarios. The MBB identifies implementation constraints/ bottlenecks of the health system that should be removed to optimize expected health outcomes and then estimates the marginal costs of overcoming those constraints.

It is important to note that to improve MMR strategies should:

- Be innovative in building on what already exists
- Be committed to sustained resource mobilisation
- Be investing in overcoming identified bottlenecks

Intra-partum care strategy

Skilled attendance at delivery

Evidence shows that the best strategy for reduction in maternal mortality is likely to be one in which women routinely choose to deliver in a health centre, with midwives as the main providers (basic essential obstetric care). The treatment component would include all basic emergency obstetric functions, apart from blood transfusions or surgery which would be available at the referral level as comprehensive emergency obstetric care. Ensuring such services were close enough for women to deliver in would also ensure women were likely to be close enough if the need for emergency care arose in the antenatal or postpartum period.

Community level

It is assumed that birth giving women would opt for supervised deliveries in preference to alternatives, provided that barriers of distance, cost, and cultural acceptability are overcome, and if staff in facilities has the necessary interpersonal skills to support women.

It is observed that there are important delays in seeking maternity care - assuming the preference of skilled assistance at delivery - caused by several factors. Cultural and social factors might influence decisions to seek services and are important for access and utilisation. Transport costs are a major hidden cost for health care access, assuming that the recently enacted free delivery care has removed other financial barriers to access. There is little knowledge of traditional practices that might cause delay and that might be harmful or beneficial to pregnancy outcome.

It is believed that involving pregnant women in the governance and management of maternity services will improve the understanding of the causes and consequences of the first order of delay and consequently lead to agreed solutions (between provider and client) improving accessibility and utilisation. In several districts community participatory approaches have been tested (Millennium Villages project in Amansie West, Zorko initiative in Bongo district) leading to an increased number of deliveries conducted in facilities assisted by skilled personnel. It is important that lessons from these 'pilot' projects are learnt as a matter of urgency to enable a 'scale up'.

Some women will choose other alternatives, including home birth with a skilled attendant, relative or traditional birth attendant, particularly where there are strong beliefs in the normality of childbirth or cultural preferences for certain practices or delivery environments. There is a long history of traditional birth attendant training programmes. A systematic review lends support to early findings suggesting that trained traditional birth attendants without the support of skilled

back-up services do not reduce the maternal mortality ratio. In Ghana deliveries assisted by traditional birth attendants are not regarded as skilled care at delivery.

First line contact with health system

In Ghana access to skilled care at delivery is dependent on geographic location and income status. Three Northern Regions have lowest access with 0-30% while Greater Accra has the best with 71-80%. More than 61% of rich urban women have access to doctor assisted delivery.

It is perceived that quality of clinical medical care is substandard. 'Quality of Care' scores are generally low, with large geographic differences. This has a proven direct relationship with utilisation. Poor quality delivery care will undermine the objectives of the current free delivery policy.

To ameliorate these constraints it has been suggested to develop and enhance Public Private Partnerships (PPP) in the area of drugs and supplies procurement and distribution, logistics and ambulance services, human resources and (continuous) education.

Community Health Planning and Service compounds (CHPS) could be converted into birthing centres, although the human resource implications with the universal roll out of CHPS need to be well thought through.

While there is a need to build the capacity of the maternity workforce (both for ensuring skilled attendance and emergency obstetric care) in terms of quantity in order to reach out to all communities, it is even more important to consider quality. Community skills of midwives should be developed for joint monitoring and evaluating of maternity services and contributing to overall quality improvements. Midwives and other midwifery providers should work within a multi-professional team of health workers, including peers.

It is possible to improve access to skilled care by better utilization of existing staff, and training mid-level providers in tasks that are usually undertaken by physicians. While support workers could conduct some of the non-specialist midwifery tasks under supervision, e.g. use of National Youth Employment Programme, physicians with obstetric skills or mid-level providers with obstetric competencies (such as in selective surgical procedures) are best targeted at referral centres where surgery is possible.

Referral

Home-based care without assurance of links and transport to emergency obstetric care in facilities will limit the effectiveness of this strategy.

Maternity waiting homes as 'part and parcel' of the service package of the referral clinics might mitigate patient delay. Furthermore, to mitigate first and second order of delays it is suggested to explore ways of using cell-phones (free calls to be negotiated with communication service providers) for referral and consultation.

Support systems

There are dire human resources constraints, although the situation is improving with higher output of training centres and less international migration. Nurse/Midwife population ratio is currently estimated at 1:1,510 with large disparities for access in favour of Greater Accra and Kumasi. It has been estimated that there is a need for approximately 5,000 new midwives (cave: not yet including needs as identified above when converting CHPS into birthing centres).

In terms of increasing the number of newly trained staff, the largest barrier to overcome is the need for sufficient teachers and trainers who are competent in education and in midwifery theory and in clinical practice. To achieve the right balance between numbers and quality, adequate funds and a cost effectiveness analysis are necessary, in turn dependent upon having policies and strategies in place.

Policies and financing

It is suggested that there is a role for the National Health Insurance Scheme (NHIS) to create and enforce Public Private Partnerships (e.g. accreditation).

Emergency obstetric care strategy

Ensuring a ready supply of the emergency-obstetric care package requires that health centres and hospitals are equipped to deal with the emergencies, causing most maternal deaths, that reach them, and that timely care is not hindered by the need to pay in advance for lifesaving treatments, or to purchase essential supplies and drugs from outside the facility, or organise blood donations. Success of emergency obstetric care alone is also dependent on a means of distribution to ensure that its target - women with complications, particularly rapidly fatal intra-partum complications - can access such care, ideally within a couple of hours. This means overcoming delays in recognition of complications and referral to the facility (the so-called first delay) and in gaining timely access to appropriate emergency obstetric care services once at the facility (the second delay).

Some of the remedial action proposed under intra-partum care would be equally applicable to emergency obstetric services and will therefore not be repeated here. A brief description of some addition with respect to the first line contact with health system and referral level of the health system follows.

First line contact with health system

In Ghana there is a lack of basic infrastructure, blood transfusion service and theatres, poor geographical access (specifically in the North) to facilities and referral services.

The Christian Health association Ghana (CHAG) has conducted a study on Emergency Obstetric Care. It is advised to extend this study to other regions to increase our communal understanding of issues.

There is a need to extract important lessons from the existing Safe Motherhood Programme in Ghana that aims to improve access to Emergency Obstetric Care. This should be reflected in future integral planning (POW) to attain MDG 5 targets.

Strategies complementing intra-partum care

Antenatal Care

Antenatal care has long been regarded as a core component of routine maternal and child health services, and receives the largest allocation of budgetary resources in many developing countries. However, high-risk screening during antenatal care, as a means of identifying women for facility-based intra-partum care, is not effective, either for women who were at low or high risk when they first presented for antenatal care, and the contribution of antenatal care specifically to maternal mortality reduction has been challenged. The acknowledged benefits to the baby of antenatal care in terms of growth, risk of infection, and survival, however, remain.

Focused Antenatal Care (FANC) has been introduced as a new way to provide antenatal services in three hospitals (Tema General Hospital, Koforidua New Juaben Hospital and Tamale General Hospital). Results indicate increasing Antenatal Care registration and improved pregnancy outcomes. Important lessons from these exciting initiatives should be learnt and feed into a 'scale up'.

Family Planning and Adolescent Reproductive Health

Adverse outcomes in pregnancy are conditional on pregnancy itself, so prevention can be separated into prevention of pregnancy and prevention of risk factors for complications and disease. Family planning (FP) is an effective form of primary prevention, albeit one that applies to a restricted target group; that of women not wanting more children. A sizeable proportion of unwanted pregnancies end in (unsafe) abortion, a separate fact sheet submitted during the November 2009 Health Summit describes this problem in Ghana in some detail. Data suggest that between a quarter and two-fifths of maternal deaths could be eliminated if unplanned and unwanted pregnancies were prevented.

Recent data in Ghana suggest that knowledge about FP is reasonably high, but that use is low.

There is a large unmet need due to physical commodity and financial access issues. Decreasing fertility rates have lead to increasing unmet demand for FP and increasing abortion ratios.

As mentioned, the abortion situation and possible remedial action in Ghana has been documented elsewhere. This paper will limit itself to a description of suggestions deliberated for the improvement of FP services at the different health system levels.

Community level

Cultural, social and possibly religious factors are influencing decisions to seek FP services and its subsequent utilisation. Maternal Mortality ratio reduction is considered a human rights issue. It is therefore important to empower women with knowledge on maternal health and reproductive rights to make informed choices about their reproductive needs. Men should be involved and culturally appropriate Information Education and Communication provided utilizing modern media and social marketing.

First line contact with health system

The existing Family Planning Programme and the High Impact Rapid Delivery should be used to combine partnership, vision and evidence based methods to scale up key priority interventions universally.

Investment in Adolescent Reproductive Health is needed (e.g. adolescent friendly health services) to offer a conducive environment for the creation of awareness and implementation of reproductive rights and responsibilities among the youth.

Support systems

There is an urgent need to increase the financing base for FP commodities and to address issues of procurement and distribution, building on positive and negative experiences. Initiatives to explore the inclusion of long term to permanent contraceptive methods in the NHIS should be followed through. There are indications and supporting evidence that this could in time ensure cost savings for the scheme.

Cost and resource mobilisation

The last chapter of this paper will deal with some of the implications regarding the implementation of the suggested remedial action.

An earlier evaluation of scenarios using the MBB tool indicated that by investing an additional $15.84 per capita into total services would result in a reduction in mortality ranging from 20%- 37% for neonatal and under five's respectively. The impact on maternal mortality would result in a reduction of 35%. At the community level the analysis shows that the bottlenecks in both child and maternal health service delivery are largely on the demand side. An analysis of the coverage determinants show that the main bottlenecks in delivering population-oriented schedulable services are equally on the demand side, i.e. high access has not translated into high effective coverage of services. With regard to individual orientated clinic based services, coverage is inadequate. In analyzing the bottlenecks by determinants we clearly have challenges that are both supply and demand related. Supply issues such as inadequate number and capacity of existing staff in IMCI and EMOC predominate. There is poor physical access with only 60% the population living within 8 km from a PHC and about half the population with access to facilities providing 24 hr Basic Emergency Obstetric and Neonatal care (BEONC) and Comprehensive Emergency Obstetric and Neonatal care (CEONC). On the demand side, we have a low uptake of assisted deliveries, with only a third of births occurring in BEONC facilities and 3.6% deliveries by Caesarean Section (C/S) at higher level referral facilities. Improving the coverage of clinical services in Ghana would clearly need strategies that address both supply and demand issues.

It is suggested that the MBB evaluation is repeated on new insights and subsequent scenarios that will feed into the POW 2009 to give partners a clear understanding of resource needs and gaps/additional resources required and to solicit for additional funds (Government and Partners). Some guidance in monitoring and improving the implementation effort is offered for the different levels.

The impact of the new free maternal health care policy should be carefully followed and corrective action taken when needed.

Summary of issues

- *Build on best practises and scale up participatory approaches to increase coverage of skilled delivery*
- *Explore the role of NHIS in enhancing Public Private Partnerships to improve quality of care*
- *Convert Community Health Planning and Service compounds (CHPS) into birthing centres*
- *Engage midwives in a multi-professional team of health workers for monitoring and evaluating maternity services to increase quality of care*
- *Improve and rationalise skills mix of health staff to mitigate short term human resource constraints*
- *Promote innovations in reducing barrier to emergency obstetric care, e.g. by the use of mobile phones*
- *Scale up Focused Antenatal Care to increase Antenatal Care registration and improve pregnancy outcomes*
- *Empower women with knowledge on maternal health and reproductive rights to make informed choices about their reproductive needs*
- *Combine the existing Family Planning Programme and the High Impact Rapid Delivery to scale up key priority interventions universally*
- *Increase the financing base for FP commodities and to address issues of procurement and distribution*
- *Reach decision on inclusion of long term to permanent contraceptive methods in the NHIS benefit package*
- *Repeat the Marginal Budgeting for Bottlenecks evaluation on new insights and subsequent scenarios that will feed into the succeeding POWs*

To decide on action for each of these issues the following questions should be considered:

- Do we know enough about the problem to make appropriate recommendations?
- If not, what further information is necessary and how should we get it?
- If so, what are the policy recommendations that can be made?
- Most importantly, what are the next actions that are needed to implement these recommendations which will impact maternal mortality?

Bibliography

Campbell O.M.R. Graham W.J. Strategies for reducing maternal mortality: getting on with what works. Lancet Maternal Survival Series. Lancet 2006; 368: 1284-99

Fauveau V. Sherrat R. de Bernis l. Human resources for maternal health: multi-purpose or specialists. Human Resources for Health 2008, 6:21

Ministry of Health Ghana/Ghana Health Service/Unicef. Bottleneck analysis of Ghana's health interventions. March 2007.

Ministry of Health Ghana. National consultative meeting on the reduction of maternal mortality in Ghana: Partnership for action, a synthesis report. October 2008.

Report on the Marginal Budgeting for Bottlenecks workshop. Accra, 6-15 February 2007.

Roedde G. Summary of consultancy for UNFPA and GOG: Status of MDG 5. July 7-11 2008.

WHO, UNFPA, Unicef, The World Bank. Joint statement on maternal and newborn health. 25 September 2008.