

Maternal Health and Health Sector Reform: Opportunities and Challenges

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Summary

Over the last decade an increasing number of countries have begun implementing health sector reform programmes. There have been concerns that, in practice, the focus of the reform agenda has been more on process, such as financing and decentralisation, rather than health outcomes. This paper examines the relationship between health sector reform and safe motherhood by exploring the following four questions:

- which aspects of safe motherhood have been integrated into essential packages of health services?*
- what effect have changes in financing arrangements, in particular the introduction of user fees, had on access to maternity services?*
- how has decentralisation affected the availability of maternity services?*
- has the sector wide approach resulted in changes to the quality of maternity care?*

Although the review highlights how much we do not know, some interesting themes are emerging.

Many countries are struggling with the introduction of an essential service package. It is clear that current levels of funding are not consistent with universal coverage of an essential service package and this inevitably has implications for extending maternal services. An opportunity presented by decentralisation is the "potential" it has to provide the continuum of care needed for effective referral. A challenge is the need to ensure a consistent policy towards maternal health issues after decentralisation, particularly the provision of sensitive services.

Donors are increasingly moving towards SWAps in order to reduce fragmentation and ensure a coherent policy framework. This provides the opportunity to influence maternal health policies but as yet there is little evidence to suggest that this has translated into improved quality of services and improved maternal health outcomes. The immediate challenge is to initiate operational research which reviews performance and the impact of HSR on maternal health services and outcomes. A number of process indicators, including deliveries conducted by a skilled attendant, can be used to track progress towards maternal mortality reduction goals. These indicators, which measure changes in the availability and quality of services, can potentially be used to measure changes occurring as a result of health systems reform.

Introduction

In the mid eighties a seminal article by Rosenfield and Maine, '*Where is the M in MCH*' drew attention to the neglect of maternal health in developing countries (Rosenfield & Maine 1987). Their concern was provoked by a growing awareness of the huge disparity in maternal mortality ratios, and life time risk of maternal death, between developed and developing countries. In 1987 a major international conference in Nairobi launched the global Safe Motherhood Initiative which was charged with improving maternal health and reducing maternal deaths by 50 % by 2000. Ten years later a review of progress at the Safe Motherhood Technical Consultation in Colombo found that, although the Initiative had been successful in increasing awareness of the problem, and, to a lesser extent, in mobilizing resources for safe motherhood activities, only a few countries had made significant progress towards the target.

The Safe Motherhood Initiative, and other advocacy movements related to women's health have had a major influence on policy development at an international level. In 1994 the International Conference on Population and Development (ICPD) recommended that countries move away from the traditional family planning (FP) projects to a broader perspective of reproductive health (RH). Although not primarily focused on maternal health and safe motherhood the Plan of Action developed at ICPD placed, and has helped to keep, maternal health within a Reproductive Health agenda. Encompassing safe motherhood within reproductive health, although welcome, has presented a conceptual problem for governments faced with competing priorities because, unlike most reproductive health services which can be provided on an out patient basis, care for women with obstetric complications is an in-patient activity and requires a functioning health service.

Most technical experts now accept that averting maternal deaths requires that women with life threatening complications of pregnancy and childbirth have access to appropriate emergency obstetric care. Some of this care can be provided at health centre level if facilities are able to perform basic emergency obstetric functions but because life saving treatment often requires obstetric surgery and blood transfusion, women also need access to the comprehensive services available at first level referral hospitals. Access to both these levels of care requires the existence of a functioning referral system. The quality of care is also crucial. Staff need to be appropriately trained and in post, there needs to be 24 hr cover, and essential drugs and supplies need to be available. All these requirements are aspects of health systems that function well. In addition, communities need to have confidence in the ability of the services to meet their needs so that they will use them (Safe Motherhood Technical Consultation 1997, World Bank 1999, Maine, 1997).

By the late nineties, increasing awareness of the problem of maternal mortality on the part of governments and donors led to the initiation of a number of safe motherhood projects designed to improve access to emergency obstetric care (e.g. Malawi, Nepal, Morocco, Ghana, Philippines). Past experience, particularly with family planning programmes, had demonstrated that vertically focused projects could produce good results which have a positive impact on health status and can be targeted at the poor. Most of the safe motherhood pilots followed this pattern. However, the experience of implementation has highlighted a number of drawbacks to this approach. First and foremost a number of project initiatives have been seriously compromised by inherent weaknesses within the health systems in which they operate. These weaknesses include inappropriate deployment and rapid turnover of skilled staff, poor maintenance of equipment, interruptions in essential drug supplies and generally poor management and morale. Lack of sustainability, particularly where there is a high degree of dependence on external donor support, is a major drawback. Other problems are duplication of activities and lack of integration with, and support for, other district level hospital and primary care services.

The experience gained from attempting to implement safe motherhood initiatives within dysfunctional health systems has awakened interest in the handful of countries which have succeeded in achieving significant and sustained falls in maternal mortality ratios. There are

several well-documented success stories including Malaysia, Sri Lanka, Kerala State in India, Iran, Cuba, and China. Although some of these countries have quite low GNP, the common factor seems to be that they have concentrated on meeting the basic health and other needs of the population and have focused investments on health systems development generally and maternal health services specifically (Safe Motherhood Technical Consultation 1997, Koblinsky *et al.* 1999, World Bank 1999). These observations, combined with the growing interest in health system development, have raised questions about the possible opportunities and challenges that health sector reform might present for safe motherhood.

Over the last decade an increasing number of countries have begun implementing health sector reform programmes. The goal of health sector reform is to improve the health status of populations by promoting and enhancing access, equity, quality, sustainability and efficiency in the delivery of health services to the largest possible number of people (Langer *et al.* 2000). There have been concerns that, in practice, the focus of the reform agenda has been more on process, such as financing and decentralisation, rather than health outcomes.

In practice, health sector reform involves multiple interventions, many of which are interdependent and carried out simultaneously. Although there is no standard package of health sector reform, the main strategies involved are:

- improving the efficiency of the public sector through decentralisation;
- concentrating limited government finances on an essential package of services;
- developing alternative financing mechanisms;
- increasing involvement of the private sector through contracting and regulation; and,
- introducing sustainability and greater government ownership through sector wide approaches.

Comparing and contrasting experiences with health sector reform is difficult, both because the components vary from country to country, and because countries are at disparate stages of implementing their reform initiatives. A review of the literature has been used to prepare this paper but it has been complemented by country experience and discussions with key informants to provide a more balanced picture.

Health sector reform is a very broad concept. This paper examines the relationship between health sector reform and safe motherhood by exploring the following four questions:

- which aspects of safe motherhood have been integrated into essential packages of health services?
- what effect have changes in financing arrangements, in particular the introduction of user fees, had on access to maternity services?
- how has decentralisation affected the availability of maternity services?
- has the sector wide approach resulted in changes to the quality of maternity care?

Which Aspects of Safe Motherhood Have Been Integrated into Essential Packages of Health Services?

There are two main reasons for developing an essential service package. The first is to assist development partners in setting priorities within fixed financial resources using cost effectiveness as the main criteria (IHSD 1999). The second is to meet the needs of users by providing services together in one place on the same day (UNFPA 1999).

In 1994 WHO published the Mother Baby Package (MBP) bringing in influencing allocations of budget and advocating for more resources (together the basic components of maternal and neonatal care). Components include family planning, antenatal care, clean safe delivery, and access to emergency obstetric care (WHO 1996). Although some of the recommendations included in the MBP, such as the risk approach to antenatal care, are now disputed, the MBP

still serves as a practical guide to the minimum services needed to address the needs of pregnant women and their babies. In Uganda, and in some other countries, cost data based on the mother and baby package has been instrumental (WHO 1996).

In most health system reform programmes the essential service package normally contains, as a minimum, immunization, pre and postnatal care, oral rehydration, treatment for malaria and lower respiratory infections, and family planning. Clean safe delivery is sometimes, but not always included however, emergency obstetric care is frequently omitted. A survey by Family Care International identified maternal health components in the essential service package in Zambia, Bangladesh, India, Senegal, South Africa, Uganda and Mexico (Family Care International 1999, Hardee *et al.* 2000).

Delivering an essential service package requires that staff are trained in many different skills. This process is commonly referred to as multi-skilling. Although multi-skilling is desirable, it is important to recognise that specialised skills continue to be essential for running a health service (Wilkinson 1999). This is particularly important for reducing maternal mortality as health workers with trained in midwifery are needed to ensure the provision of safe delivery and quality maternal health services (Population Council 1998).

Most countries are struggling with the concept of an essential service package because it often represents an increase in the range of services available at the periphery. Existing resources tend to be tied up in salary costs leaving little freedom for expansion. It is clear that current levels of funding are not consistent with universal coverage of an essential service package and this inevitably has implications for extending maternal services (Foster *et al.* 2000b).

What Effect Have Changes in Financing Arrangements, in Particular the Introduction of User Fees, Had on Access to Maternity Services?

Health Sector Reform programmes usually require examination of, and sometimes changes in, financing arrangements. Three main financing modalities are generally considered: improved mechanisms for public funding; user fees; and, health insurance. Of these, user fees is the one that has been the most enthusiastically embraced by developing country governments (though not necessarily endorsed by donors).

Studies have revealed a number of examples, e.g. Kenya, Tanzania, Papua New Guinea, where the introduction of user fees has been accompanied by a decline in the use of maternal health services, particularly of the poorest (Family Care International 1999, Ambrose 2000). However, some authors argue that this usually reflects poor design, planning and implementation, resulting in inadequate attention to ensuring quality improvements and the design of exemption mechanisms, and insufficient involvement of those who will implement the systems within the wider community (Bennett 2000).

In cases where user fees have been implemented along with fee exemptions and, most importantly quality improvements, use of health services has been observed to increase (Leighton 1999). For example, in Niger, a combination of user fees and improved service delivery resulted in increased use of antenatal services (Leighton 1998). There is now substantial evidence to suggest that if the health facility is able to retain and reinvest user fees, the quality of services improves with an increased utilisation by the poor (Family Care International 1999, Langer *et al.* 2000, Borghi 2000).

Mechanisms to protect the poor are very difficult to implement in practice and various options have been tried. In Bangladesh and Colombia sliding scales have been introduced to protect the poor but they are subject to favouritism (Borghi 2000). In West Africa various loan schemes have been tried to encourage increased utilisation of emergency services. The schemes allowed payment to be deferred or paid in small instalments (Fofana *et al.* 1997). The result of these schemes found a positive effect on utilisation of emergency services, particularly a reduction in delay. Nevertheless, there were concerns, about the sustainability

of the schemes as they were very dependent on strong community leadership, and required substantial community mobilisation (Fofana *et al.* 1997, Chiwuzie *et al.* 1997). Calls for free-to-user services are associated with studies linking free services to increased utilisation of maternal services (Langer *et al.* 2000, Schneider *et al.* 1999). Certainly changing to free MCH services in South Africa resulted in an increased use of antenatal and paediatric services but significantly did not increase the use of facilities for delivery (Schneider 1999). In many countries services are 'free' in name only and the introduction of transparent user fees can actually reduce the cost to consumers as well as making more money available to the health facility as opposed to the individual providers.

How Has Decentralisation Affected the Availability of Maternity Services?

Decentralisation is a process by which authority, functions and financial resources are progressively transferred to lower level units. The aim of decentralization is to improve the effectiveness and efficiency of the health system by developing health systems that are appropriate and accountable to local needs and which allow managers to manage (Bossert 1997). In the health sector, the initial process has usually involved deconcentration³ of powers, with decentralisation only taking place when it is part of the wider political agenda of local government (Hardee & Smith 2000).

Decentralisation has been most successful in countries where the process took place slowly in line with improvements in local capacity. This suggests that the process may be better suited to more mature and developed health systems. (Langer *et al.* 2000, Hardee *et al.* 2000, Aitken 1999). There seems to be a tendency to underestimate the complex nature of the decentralisation process and to introduce decentralisation as a reform when the public health system is in crisis. This results in exacerbating the mismanagement problems and the neglect of health services (Population Council 1998, Hardee & Smith 2000, FPLM 2000).

Evidence from Ghana, Indonesia, Papua New Guinea suggests that a positive feature of decentralisation has been the emphasis on development of the district health system (DHS). However, difficulties have been encountered in breaking down the pre decentralization vertical allegiances (WHO 1997, Aitken 1999, Agyepong 1999). Agyepong makes the point that in Ghana utilisation of ante natal care did not increase as expected after decentralisation because MCH services continued to be seen as divisional responsibility rather than a district essential service (Agyepong 1999).

It is difficult to be certain of the extent to which decentralisation has supported maternity services. However, it is argued that a functioning district system has the "potential" to provide the continuum of care needed for effective referral from communities to emergency obstetric care facilities. The World Bank has credited the success of a safe motherhood project in Chad to activities which focused on the development of the health system from the community to the referral centres (WB 1999). Other recent success stories include Iran, the Philippines and Papua New Guinea (WHO 1997, Tinker 1998, Aitken 1999). In Papua New Guinea the impact of decentralization on maternal health was initially limited due to low levels of institutional deliveries and transportation. The situation improved due to economic development, the adoption of standard management protocols, in service training, and radio links, though it was noted that the extent of improvement varied according to the enthusiasm of the provincial health manager (Aitken 1999).

Although there are now a number of positive experiences with decentralisation there may be adverse effects due to local disagreement with progressive central policies. For example, studies in Senegal and Indonesia examining the overall impact of decentralisation found general support for safe motherhood but local resistance to the delivery of sensitive services such as abortion, adolescent care and prevention of HIV/AIDS (IDRC 1997, Futures 2000).

³ Deconcentration is defined as shifting power from the central offices to peripheral offices of the same administrative structure. (pg 147 Bossert 1995).

Similar problems have also emerged in Zambia and the Philippines (Population Council 1998).

Has the Sector Wide Approach Resulted in Changes to the Quality of Maternity Care?

Sector Wide Approaches (SWAs) are being introduced in a number of countries. The aim is to introduce sustainability and national ownership by changing external bilateral and multilateral agencies from donors who invest in projects, to development partners who invest in country strategies and programmes that will deliver the strategy (McDonagh *et al.* 2000). Key steps include: a sector strategy that is jointly agreed between the Government, civil society and external development partners; a programme implementation plan or sector investment plan that will deliver that strategy and allocation of funding to support it (McDonagh *et al.* 2000). However, there are no blue prints. SWAs are a process approach, as demonstrated by the fact that currently each health SWA has very different funding arrangements (WHO 1999).

Many countries are moving towards SWAs in order to reduce policy fragmentation and the managerial overload placed on governments by disparate projects (Cassels & Janovsky 1998). The overall benefit generally, and specifically for maternal health, is the provision of support within “ a coherent overall budget ensuring that recurrent cost implications and new investment are fully planned for” (Foster *et al.* 2000).

There is currently very little evidence available examining the impact of SWAs on the quality of services or maternal health outcomes and some would argue that it is too early to draw any conclusions (Johanson 2000, McDonagh *et al.* 2000). The available literature focuses on the policy process which is developing between donors and government within a sector wide approach and the development of the systems and processes involved (Foster *et al.* 2000b, Johanson 2000). A study by WHO confirmed this by finding that most SWAs have been more successful in tracking process and financial flows than health outcomes (WHO 1999). A review by the World Bank of their safe motherhood projects found that working at sector level had been very important in agreeing maternal health policies and priorities (World Bank 1999).

A recent study commissioned by WHO reviewed five countries implementing SWAs and found that links between policy and implementation were growing and that progress had been made in the diagnosis of barriers to service utilisation (Foster *et al.* 2000b). It can be legitimately presumed, therefore, that an improvement in quality was not observed. It was felt that the evidence that service delivery had suffered under the transition to SWAs was largely anecdotal but acknowledged that this issue required further investigation (Foster *et al.* 2000b).

Discussion

There is a growing body of literature describing the impact of HSR on Reproductive Health (RH) status (Population Council 1998, Langer *et al.* 2000, Lush *et al.* 1999, Hardee & Smith 2000, Papineau 2000, Langer *et al.* 2000). However, few authors have focused specifically on the impact of HSR initiatives on maternal health and services, although interest does appear to be growing (Goodburn & Campbell 2001, World Bank 1999, Aitkin 1999). Much of the available literature is 'conceptual' in nature with little formally documented operational evidence. The former focus on using maternal mortality to measure the impact of changes in health care systems may be partly to blame for this situation. It is now accepted that measuring maternal mortality is expensive and impractical at programme level, and that proxy, service delivery, indicators are required. However, systems for collecting service delivery data are still in the development phase in many countries, and so these data are often not yet available for use. Perhaps because of this lack of data, the academic literature is distinctly polarised with health reform protagonists and antagonists firmly positioned in their respective camps.

There is no clear definition or universally agreed package of HSR. This means that disparate activities are being grouped together, termed HSR, and then pronounced a success or failure without any consistent definition of cause or effect. There is probably no justification for trying to promote a uniform HSR package, as HSR is a process not a collection of activities. Nevertheless, it is important to disaggregate the individual interventions usually included in HSR and look for evidence of effect so that lessons can be incorporated into future policy and practice. In such a diverse field, clarity of meaning is important. We noted a number of incidents of confused terminology, particularly between HSR and SWAps. SWAps may be part of a reform agenda or may include reform activities as part of the agreed strategy, but they are not synonymous with HSR.

It is true that many HSR initiatives are more focused on process than health outcomes (WHO 1999, Foster *et al.* 2000b). However, many of the processes involved in HSR also provide opportunities. Evidence from key informants suggests that the process of discussing the components of a sector strategy, or an essential service package, highlights the issues surrounding the delivery of maternal health services, even if these issues are not immediately resolved (McDonagh *et al.* 2000). This means that it is important to participate early and positively in HSR initiatives in order to be strategically positioned to influence the process (McDonagh *et al.* 2000).

One of the most important challenges facing HSR initiatives is to ensure they become more outcome focused. Process indicators, such as deliveries conducted by a skilled attendant and met need for essential obstetric care, can be used to track progress towards maternal mortality reduction goals. These indicators, which measure changes in the availability and quality of services, can potentially be used to measure changes occurring as a result of health systems reform.

Donors are increasingly attracted towards working through SWAps. However, there continues to be considerable misunderstanding and misinformation about this approach. The opportunities and challenges of working within a SWAp merit a particular focus. The philosophy of the SWAp process is that government leads it, as political commitment is an essential ingredient for a successful reform agenda, SWAps have the potential to be an effective process for reform activities (Cassels 1996, World Bank 1999). One of the opportunities of a SWAp is that it provides donors with a greater opportunity to address deeper systemic problems, permitting donors to work within a wider policy context of civil service reform and efforts to improve the budget process. (Foster *et al.* 2000, Johanson 2000).

Donors with a special interest in reproductive health sometimes voice concerns that participation in SWAps will dilute the focus and funding for specific services such as family planning. This concern increases when "pooled or basket funding" is proposed. There is

certainly a risk that governments may choose different priorities than donors. This may lead to the view that the process has been a failure when in reality it is a difference in expectations. The solution is to ensure that mechanisms exist which can be used to protect particular services if necessary, such as ring fencing or ear marking particular funds within the overall budget.

SWAps highlight some of the fundamental weaknesses in the traditional model of funding projects and challenge donors to relinquish some of their power. However, a recent review of SWAp programmes found significant similarities between SWAp programme content and implementation plans between countries, which may suggest that donor agendas are stronger than government leadership (Foster *et al.* 2000b). SWAps require donors to give governments the space to make policy, to support their priorities without imposing their own, and to back off from the detail of decision making and implementation. This process is likely to be slow and many donors still behave as if they are managing projects rather than supporting programmes (Foster *et al.* 2000b).

The role and importance of efficient health systems in reducing maternal mortality is now generally accepted (World Bank 1999, Goodburn & Campbell 2001, Papineau Salim 2000). HSR initiatives, particularly SWAps, provide the opportunity for donors to work together, in support of policies and strategies leading to the development of effective and efficient health systems. There are of course major challenges in working through a reform agenda, one of which is that there are no blue prints or quick fixes. There is no substitute for a good institutional analysis of the health system that seeks out the potential for, and the ability of the system to change (Cassels 1998, Johanson 2000). The result in most cases is likely to be a mix of new reform initiatives and old practices, with a phased implementation approach dependant on the development of capacity and performance.

Conclusion

There is a need for more evidence demonstrating the impact of HSR initiatives on MH status. The immediate challenge is to initiate operational research that investigates the effect of HSR on maternal health service delivery. A number of process indicators, including deliveries conducted by a skilled attendant, can be used to track progress towards maternal mortality reduction goals. These indicators, which measure changes in the availability and quality of services, can potentially be used to measure changes occurring as a result of health systems reform. The lessons learnt must be incorporated into future policy and practice so that the reform process results in improvements in both quality, and equity of access, to maternal health care.

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