



Going from Bad to Worse:

Malawi's Maternal Mortality



Going from Bad to Worse: Malawi's Maternal Mortality

*The problem summarised with recommendations
for national and international stakeholders*

Commissioned by Task Force 4 of the UN Millennium Project

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This paper gives an overview of challenges presented by the maternal mortality ratio in Malawi. It is abridged from a full analysis of the clinical, health systems and underlying reasons for the problem. For copies of the full text with references, please write to:

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INTRODUCTION

Over the course of the 1990s Malawi's maternal mortality ratio (MMR) doubled to one of the highest in the world. According to the 2000 Malawi Demographic and Health Survey (MDHS) the MMR is estimated to be 1 120 per 100 000 live births, nearly double the MMR of 620 per 100 000 live births estimated from the 1992 MDHS. How is it that maternal mortality could have doubled in the decade preceding the new millennium?

This document gives an overview of the factors contributing to the decline in maternal health. It begins by providing a background to Malawi, including a brief description of its social, economic and health systems context. It goes on to give an account of the clinical causes of maternal mortality. It describes how the high MMR is the result of poor health care, health systems deficiencies, poor access to care and harmful 'patient-related behaviour'.

A detailed analysis of the problem and the various options for improving maternal health is available in the full version of this document. This summary carries the concrete set of recommendations flowing from the analysis for the changes and interventions required to reduce the current MMR to about 150 by the year 2015 (in accordance with the MDG target of reducing 1990 MMR levels by 75%).



MALAWI

Malawi, with a population of about 11.5 million, is one of the poorest countries in the world. Its estimated per capita gross national income in 2000 was only US\$170. A predominantly rural and agrarian society, Malawi's economy is extremely weak and fragile. Sixty-five percent of the population is unable to meet daily consumption needs. Food insecurity is a persistent and widespread reality for most Malawian households.

Life expectancy

Malawi's life expectancy at birth is a mere 38.5 years and its Human Development Index ranks it 163 out of 173 countries in the world. A third of under-five year olds are chronically malnourished or stunted. There has been a modest decline in child mortality rates over the last decade, but one child in five still dies before their fifth birthday. The national HIV prevalence is 8.4%, and AIDS is now the leading cause of death in the 20-49 years age group. An estimated 500 000 to 800 000 orphans have lost one or both parents.

Socio-economic inequality

In spite of a high degree of generalised poverty, there are considerable socio-economic inequities with the richest 20% of the population consuming 60% of goods and services, compared to only 6% by the poorest 20%. Poverty levels are highest in the Southern Region, and worse in rural rather than urban areas. Women are disadvantaged in their access to health, education, and agriculture services. These trends appear to be deepening.



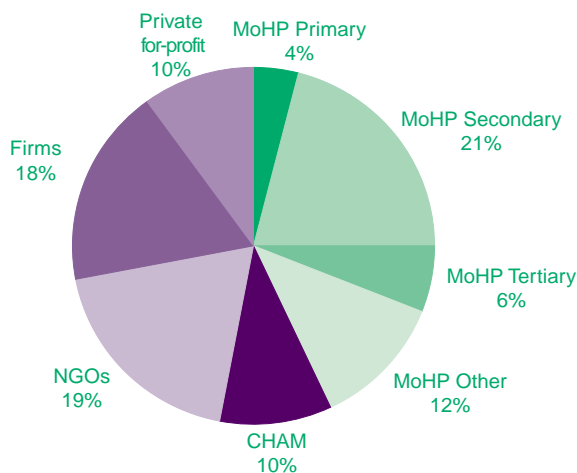
HEALTH CARE IN MALAWI

Malawi's health system is grossly under-resourced. Annual per capita expenditure is now approximately US\$12, inadequate for the delivery of basic Primary Health Care (PHC) which, in 2002, was costed at a figure of US\$1753 for the delivery of only a narrow package of essential health services.

Health care providers

Health services are provided by a number of different providers. Figure 1 shows that in 1998/9, 60% of 'formal' health facilities were government-run and 26% of health facilities were mission facilities (mainly found in the rural areas). A small private-for-profit health sector is limited mainly to the urban areas (including three private hospitals), as well as health services provided by private companies. Mission facilities largely operate independently but collectively form a loose association called the Christian Hospital Association of Malawi (CHAM). Other sources of health care include NGO projects, grocery stores and pharmacies, community-based distribution agents for family planning commodities and drug revolving funds operated by community volunteers. There is also a substantial traditional health sector. For example, approximately 23% of deliveries are attended by a traditional birth attendant and most communities have a traditional healer.

Figure 1: Health expenditure in Malawi, 1998/9 financial year



Source:
Chart 4.2, National Health Accounts 2001

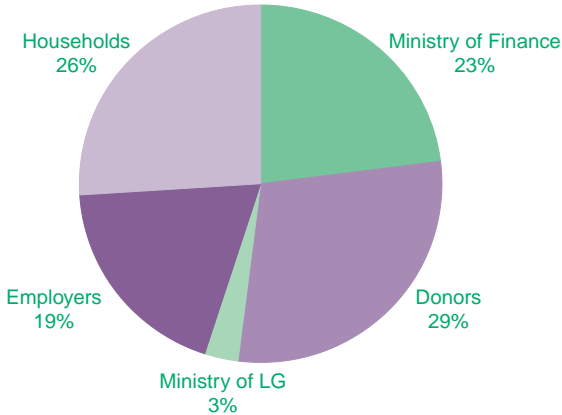
Funding health care in Malawi

As reflected in Figure 2, government revenue provides 26% of the country's health care financing, of which 3% is raised through local government. Most government revenue is used to fund public sector health services, but a portion is used to pay for the salaries of Malawian staff working in mission health facilities. Donor assistance provides approximately 29% of the overall health sector resource envelope.

Approximately 19% of funding is from employers in the 'private' sector providing health care for employees (mainly on the large agricultural estates). The remaining 26% of total expenditure is from out-of-pocket expenditure by households consisting of both the direct costs of accessing health facilities as well as the costs of user fees.

It should be noted that this pattern of health care financing reflects a period of time prior to the approved budget for Malawi's two grant applications to the Global Fund for AIDS, TB and Malaria (GFATM). This will contribute an additional \$30 million a year if the funds are fully disbursed and roughly increase per capita expenditure by a further \$3 per person per year.

Figure 2. The source of health care financing, 1998/9 financial year



Source:
Chart 4.2, National Health Accounts 2001

Organising health care

The health system is divided into 27 districts comprising 4 urban central/tertiary health facilities; 22 government district hospitals; 18 mission hospitals and a network of government and mission run health centres, maternity units and dispensaries. There are 13 899 hospital beds in the country, 36% of which are in mission hospitals. The hospital bed to population ratio is 1:842 which is low/medium compared to other similar developing countries.

Health care resources are unevenly and inadequately distributed in Malawi. Only 46% of the population has access to a formal health facility within a 5km radius, and only 20% of the population lives within 25 km of a hospital. Access is worse in the rural areas. There is a particularly significant mal-distribution of health personnel, which favours urban areas, and the secondary and tertiary levels of care. Health care resources in many rural areas could be as little as 10-20% of that required to provide a narrow package of essential health services.

'The poor wait longer, receive fewer drugs and pay more'

Assessments of peripheral health units have found shortages of drugs in almost all hospitals and clinics. Other problems with government health facilities include poor staff attitudes, patronage, long waiting times and a lack of confidentiality. These deficiencies are worse for people living in rural and geographically remote areas.



MATERNAL MORTALITY IN MALAWI

What is maternal mortality?

A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management. A maternal death may be a direct obstetric death, that is resulting from obstetric complications of the pregnant state (pregnancy, labour, and the puerperium), from interventions, omissions, or incorrect treatment, or from a chain of events resulting from any of the above; or it may be an indirect death, resulting from previous existing disease or disease that developed during pregnancy and that was not due to direct obstetric causes but was aggravated by the physiological effects of pregnancy.

According to the 1992 MDHS the MMR was estimated to be 620 per 100 000 live births. This had nearly doubled, to 1 120 per 100 000 live births, by 2000.

What is causing maternal mortality in Malawi?

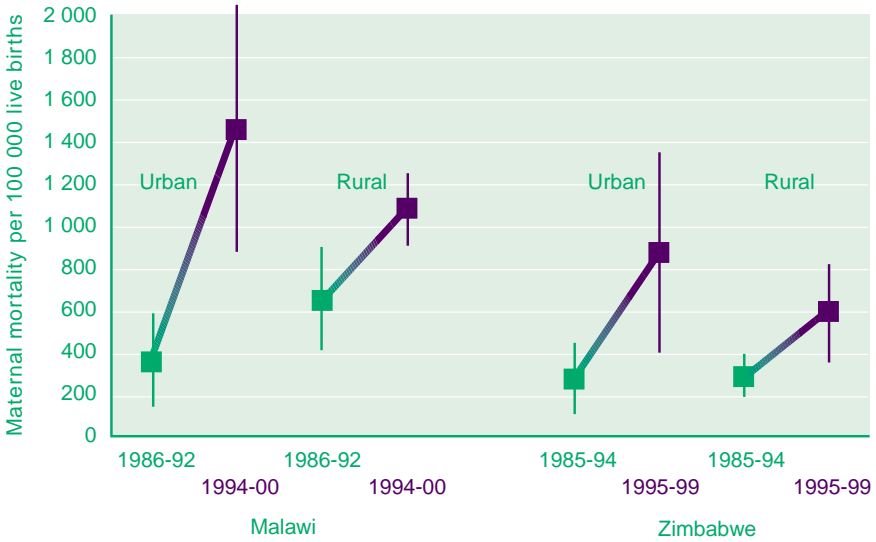
In a 2001 inquiry conducted by Ratsma into 312 institutional maternal deaths in the Southern Region of Malawi (excluding the tertiary hospital in Blantyre), roughly two-thirds (197) of deaths were direct obstetric deaths, whilst one-third (107) had an indirect cause. The majority of direct maternal deaths were due to sepsis, obstructed labour and ruptured uterus, obstetric haemorrhage (ante-partum and post-partum) and complications of abortion and eclampsia. Anaemia and AIDS each accounted for about a quarter of all indirect maternal deaths (approximately 9% of all audited deaths). Meningitis, malaria and pneumonia were the next most common causes of indirect deaths.

The precise impact of HIV/AIDS may however be more significant than the figures suggested by the Southern Region audit. This is suggested by the fact that the all-cause adult female mortality rate has increased in Malawi and is thought to be due to AIDS. In addition, a comparison of the MMR in rural and urban areas shows a much greater



deterioration in maternal health in urban areas compared to rural areas, one explanation of which is the generally higher HIV prevalence in urban areas (Figure 3). While the rise in AIDS-attributable deaths in the pregnant population could be less than in the general female population (pregnant women are generally healthier and at less advanced stages of HIV infection), there could be a tendency to report the deaths of women of reproductive age as maternal deaths to avoid the stigmatisation associated with a possible AIDS death. This might be a possible partial explanation for the alarming rise in MMR.

Figure 3: Maternal mortality ratio trends in Malawi and Zimbabwe during the 1990s (period estimate with 95% confidence limits)

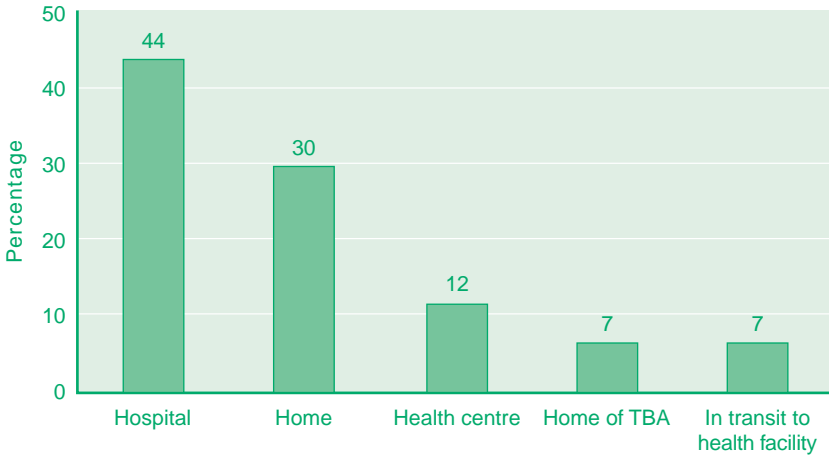


Source:
Bicego et al, 2001

Where are maternal deaths taking place?

Data on the location of maternal deaths is imprecise. However, a significant number of maternal deaths occur outside of the health care system. A community audit of all maternal deaths in Nankumba (population 62 327) revealed that approximately 44% of maternal deaths occurred either at the patient's home, the home of a TBA or in transit to a health facility (Figure 4). A high proportion of these community-based deaths are due to obstetric haemorrhage, ruptured uterus, obstructed labour, and complications of abortion.

Figure 4: Place of maternal death in Nankumba



The avoidability of maternal deaths

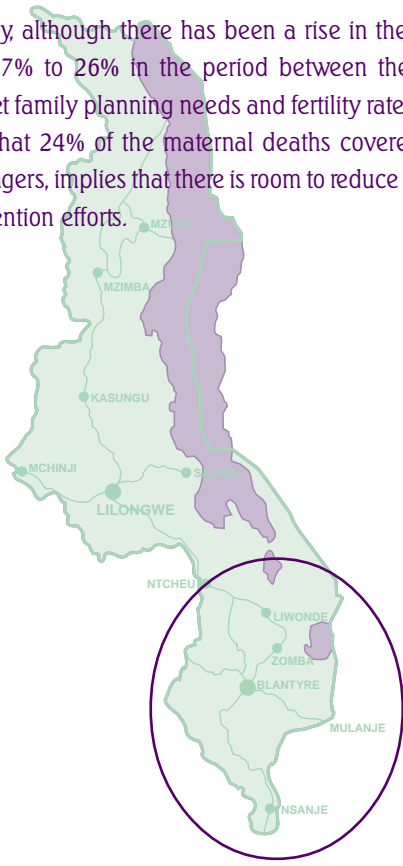
The Southern Region audit found that the quality of care had been 'sub-standard' in 62% of deaths. Deficient hospital care was the principal avoidable factor in 38% of deaths, and deficient health centre care in 5% of deaths. Delay on the part of the patient in utilising the health service was the principal avoidable factor in 15% of maternal deaths. Only in 5% of women was a 'contraindicated pregnancy' (against medical advice) the principal avoidable factor. Ten percent of all women who died were para six or more and 9% were 35 years old or more. Approximately 24% of women who died from both direct and indirect obstetric causes were teenagers.

Other research conducted over the same period in the Southern Region has found deficient health care practice including, for example, unhygienic clinical areas, deficient aseptic practices and the absence or ineffective use of partograms to monitor progress of labour.

Aspects of antenatal care may also influence maternal mortality rates. While there is reasonably good coverage of antenatal care, the quality of care provided is poor and few services provide accepted evidence-based good practice. One study of care in the Blantyre district in May-June 2001 found an incomplete coverage of pregnant women with malaria prophylaxis and many health care workers being unclear about the correct procedure for prescribing malaria prophylaxis. According to the Safe Motherhood Project, antenatal records are hardly ever completed correctly and syphilis tests are only available in hospitals and not routinely done.

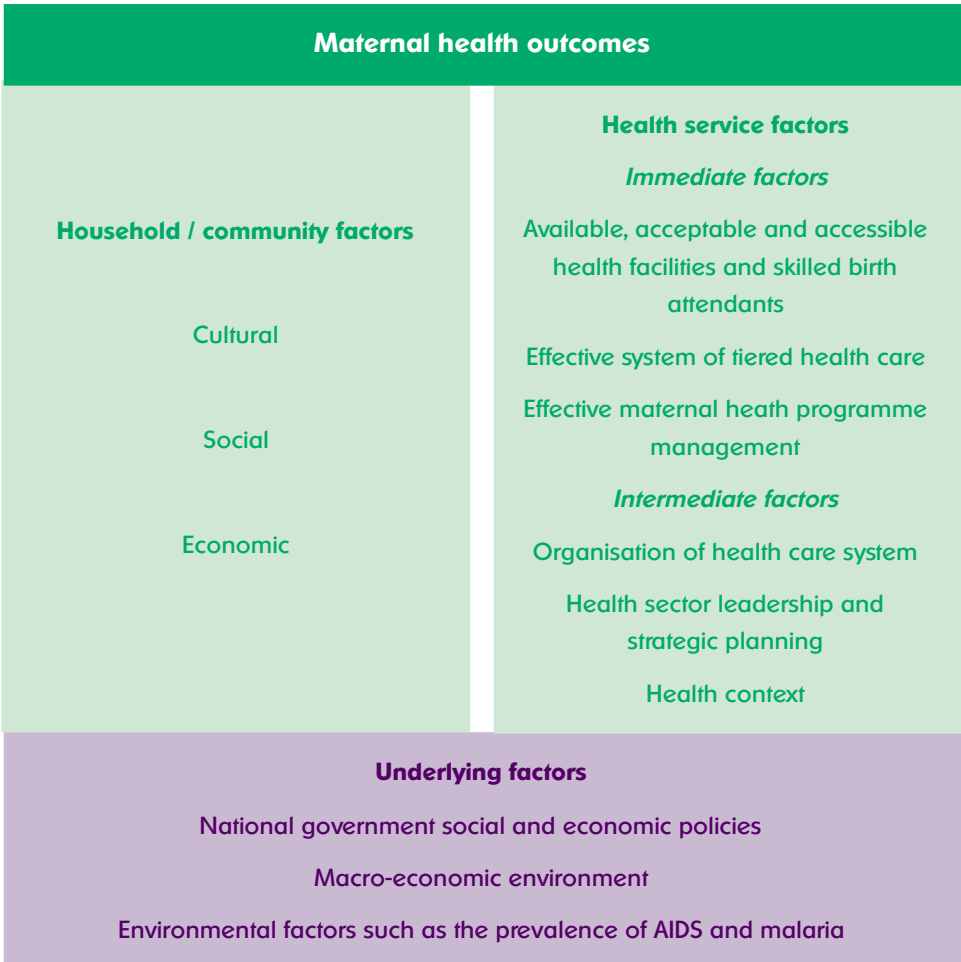
What is also notable is a strong indication that there has been a relative increase in 'deficient health centre and hospital care' as a cause of maternal mortality since the 1989 study which suggests that an actual deterioration in the quality of maternal health care underlies some of the increase in maternal mortality.

Finally, although there has been a rise in the uptake of modern family planning methods from 7% to 26% in the period between the two Malawi Demographic Health Surveys, unmet family planning needs and fertility rates (6.3 live births per woman) remain high. The fact that 24% of the maternal deaths covered by the Southern Region audit occurred in teenagers, implies that there is room to reduce maternal mortality through primary pregnancy prevention efforts.



EXPLAINING THE CAUSES OF MATERNAL MORTALITY IN MALAWI

To develop an appropriate response to the deterioration of maternal mortality in Malawi, a framework that incorporates a range of immediate, intermediate and underlying factors contributing to maternal mortality was constructed. It comprises a set of immediate and intermediate health care service and household/community factors, and a set of more basic underlying factors operating at the national and global level.



Patient and community-related factors

Skilled attendance at birth and access to high quality emergency obstetric care are essential to the reduction in maternal mortality. However, in Malawi there is a low rate of institutional deliveries. The caesarean section rate of about 3% is an indication that the access to and uptake of modern obstetric care is low. Furthermore, even when obstetric care is accessed, there is evidence of significant delays in reaching health facilities. There are several patient and community-related reasons for this.

Poor quality care

The low institutional delivery rate may be due, in part, to women choosing not to deliver in health facilities because of previous experience with poor quality care, or a perception and knowledge of poor quality care. In one study from the Southern Region, many women revealed that they had been mocked during labour, shouted at and even occasionally struck if they cried out in pain. These kinds of experiences are likely to be shared within a community and result in women feeling disinclined towards delivering in the same health facility.

Cultural beliefs

Cultural beliefs about pregnancy and childbirth also play a part in the high rates of home births, even when birth complications occur. For example, beliefs that obstructed labour is associated with infidelity result in some women being kept in prolonged labour at home until there is a 'confession' of infidelity. Another cultural belief is an equilibrium theory based on a hot-cold balance which dictates who can and can't come into contact with a pregnant woman, resulting in instances when men are unable to help transport a sick pregnant woman to hospital. Even when women deliver in a health facility, certain traditional practices may reduce the safety and effectiveness of maternal health care. For example, there is a reported practice of consuming local herbs, which contain oxytocin derivatives that stimulate uterine contractions, without the knowledge of health staff.

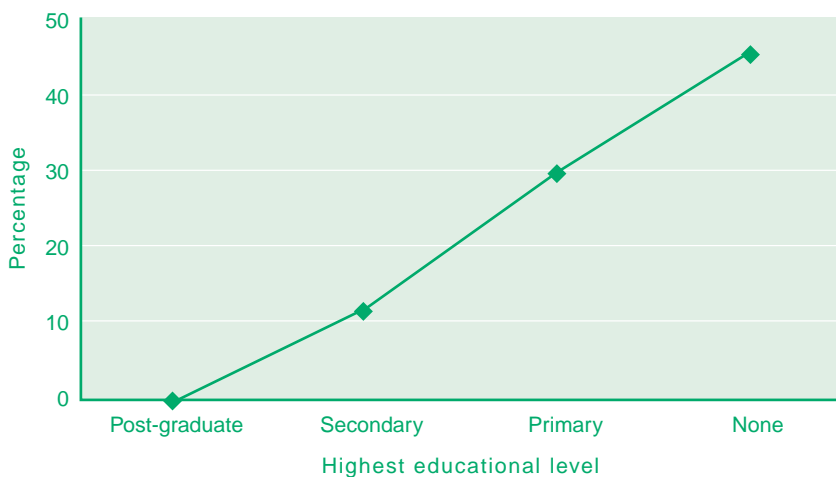
Lack of knowledge

Added to these 'cultural' practices is a lack of knowledge about the complications of pregnancy and childbirth. For example, a survey of community members in Blantyre and Nsanje found not one respondent who associated fever or fits with complications of pregnancy. The relevance of knowledge allowing an informed choice about place of delivery to be made is underscored by the fact that there is a significant correlation between knowledge about the danger signs of pregnancy with the likelihood of delivery in a health facility.

Gender imbalances

There are also gender-related imbalances in decision-making that add to the vulnerability of women. Malawi is mainly a patriarchal society dominated by men, with high levels of social disempowerment amongst women. While only 49% of women are literate, the literacy rate is 72% for men. When women are educated and improve their social standing, they are better able to make decisions that influence their health. In Malawi, educated women are more likely to seek care in a maternity unit (see Figure 5). Although this may be due to the fact that a higher proportion of educated women live in urban areas where health facilities are more accessible, it is likely that a higher education status also allows women to more successfully access the household resources required to deliver in a health facility.

Figure 5: Unskilled delivery by education status (n=1 617; p=0.005)



Source:

Ashwood-Smith H, Coombes Y, Bokosi M: 2004: Evaluating the Effectiveness of an Information, Education and Communication Strategy to improve maternal health in Malawi. Malawi Safe Motherhood Report.

Financial barriers

As 65% of the population live in poverty, financial barriers represent a further barrier to accessing health care. User fees for delivery at mission hospitals are said to vary from 50 to 400 Malawian Kwacha and are a partial cause of this financial burden. Even where services are provided free of charge (in all public health facilities), the costs (in time and personal finances) of accessing the facility present a significant barrier to care. Poor transport services add to the financial barriers to care.

Transport

Poor transport services add to the financial barriers to care and compound the large distances that some women have to travel to reach a health facility. In one study of two rural districts, 65% of post-partum respondents said that they had waited longer than 2 hours for transport whilst in labour, with 30% of women having waited longer than 4 hours. Many labouring women even end up walking to health centres, either because of a lack of transport or because transportation was unaffordable.

Health service factors

Availability, accessibility and acceptability of health facilities

The Southern Region maternal mortality audit identified delay in accessing a health facility as being a contributory factor in more than 15% of maternal deaths. While access to primary level health and antenatal facilities may be judged to be reasonable, the availability of emergency obstetric care (EOC) is poor. Only 20% of the population lives within 25 km of a hospital, which could treat all obstetric emergencies. Of those facilities that do exist, many have poor standards of physical infrastructure, which may act as a further deterrent to facility-based delivery.

Few skilled birth attendants

Attending a health facility does not guarantee adequate antenatal or intra-partum care. One reason for this is an absolute shortage of nurses, midwives and doctors. Many health centres are staffed by only one enrolled nurse-midwife. In the Southern Region, 14 out of 180 maternity units (8%) have been closed due to lack of staff. In other health facilities, unskilled and untrained staff are left to conduct deliveries. Compounding the low staffing levels and poor motivation is a relatively low skills and knowledge base amongst staff, all of which combine to result in poor quality care.

Maternal health programme design

Maternal health has received strong technical support and strategic guidance. The presence of a large donor-funded reproductive health programme has resulted in a large number of training initiatives as well as the development of many maternal health policies and clinical guidelines. However, until recently, approaches in Malawi have tended to focus on improving antenatal care, training traditional birth attendants and identifying high-risk women, at the expense of emphasising the importance of all women having access to emergency obstetric care. Although antenatal care and screening for risk factors are an important part of good obstetric practice, and can help reduce the incidence of maternal deaths, it is vital that

effective emergency care can be provided to pregnant women when they need it. The growing significance of HIV/AIDS as a cause of maternal mortality also means that there is a need to improve access to medical care for pregnant women if the MMR is to fall.

Health personnel capacity

The inadequate number of midwives and other skilled birth attendants is part of a wider shortage of skilled health personnel in Malawi where an estimated 50% of Ministry of Health and Population (MoHP) posts are currently unfilled. There is only one physician per 50 to 100 000 people (compared to the WHO recommendation of 1:12 000), and the nurse-to-population ratio is approximately 1:3 500 compared to an average of about 1:1 000 for Africa in 1998. One of the reasons for the low staffing levels is the loss of staff to the international market for trained health workers. In addition to the international migration of health personnel, there is also an 'internal brain drain'. Generally speaking, skilled health workers tend to move from the rural to urban areas, as well as from the public sector to international NGOs, research projects and para-statal agencies that provide better salaries, better working conditions or both.

Another problem has been the effect of HIV/AIDS on the attrition of health personnel due to high rates of absenteeism, illness and death. Nurses are also leaving the profession because of fear of HIV infection, a fear that is given validity by a recent finding that more than half those health workers giving vaccinations or curative injections had suffered at least one needle-stick injury in the preceding 12 months.

On the supply side, Malawi's capacity to replace lost health workers by producing new ones has also been under pressure. The staff establishments of training institutions themselves are being denuded by the general attrition of skilled personnel from the health sector. Furthermore, there are also limits to the size and capacity of some training institutions. For example, the College of Medicine in Malawi only graduates approximately 20 doctors a year (96 have graduated since it opened in 1991).

Attempts to increase the volume of new health workers are also constrained by inadequate funding. An ambitious human resources (HR) plan produced by the MoHP in 2000 could not be implemented because of a lack of funding. Even an emergency training plan, which targeted the training of priority cadres of staff, failed to gain sufficiently large commitments of funds in the timeframes required.

Of the staff who remain, particularly those in the under-resourced rural areas, many are demoralised, demotivated and complain of a lack of supportive supervision, low wages, lack of recognition and appreciation, high work loads, poor working conditions and few



career prospects. This contributes to negative feelings and attitudes towards patients.

Health systems organisation and management

Another factor which has contributed to deterioration in maternal health care is a failing capacity to organise health services effectively.

The Southern Region audit of maternal deaths indicated that the inability of the health system to refer high-risk and emergency patients to appropriate levels of care, contributed to poor maternal health outcomes. In some instances, the lack of transport and inadequate

telecommunications infrastructure undermined the concept of a tiered health system.

Rationally organised tiered health care is also undermined by the fragmentation of the health care system. Malawi's health system consists of a patchwork of public sector services, mission hospital services, donor programmes and NGO projects. Even the CHAM facilities operate as a network of autonomous facilities; although there is some shared administration, each mission facility operates independently with, for example, different user fee schedules and clinical policies.

Therefore, within a district, clinics, health centres and hospitals fall under different authorities. Although all health districts have a government-employed District Health Officer (DHO) who is nominally responsible for the coordination and supervision of all district health services within his/her boundaries, in practice, many NGOs and mission facilities operate independently of the DHO, and in parallel to government health services.

The capacity to organise services effectively is also hampered by the lack of management capacity at the district level due to many of the human resource problems described earlier. Low pay and high staff turnovers also mean people being put into management positions soon after completing their basic under-graduate training.

Health sector leadership and management

Informants from within Malawi attribute the problems with the health system to a lack of resources and a failure to implement policy, as opposed to a failure of policy development per se. The clear planning around the Essential Health Package (EHP), Malawi's quick and

successful submission of a plan and budget to the Global Fund for AIDS, TB and Malaria (GFATM) as well as its wide array of programmatic plans and clinical guidelines suggest reasonable policy development capacity. There seems however to be a weakness in operational planning, management and efficient administration. Administrative inadequacies compound the human resource crisis. There have also been well documented failings with the management of the accounting and procurements systems, and of the Central Medical Stores. One review of human resources described minimal amounts of management training as well as the role and definition of managers within the service being ill defined. Such failings in the basic bureaucracy of the Ministry of Health undoubtedly have negative effects on the quality of care provided.

These problems are partly a result of inadequate human capacity. Poor remuneration coupled with many civil servants operating at levels beyond their capacity has resulted in demotivation and demoralisation, and consequently poor performance. And finally, an element of patronage and petty corruption undermines the rational and rules-based underpinnings of the bureaucracy.

Donor dependency

Malawi's status as a poor and indebted country has also resulted in a great degree of donor dependency, which can make long-term and strategic management difficult. A tendency for donors to stake their claim on particular districts or vertical projects, with their own health priorities, training thrusts, information requirements, and financial systems, with little regard for national system requirements also undermines the capacity for effective and integrated management. Donors have also been guilty of funding capital projects without due consideration of the recurrent cost implications.

HIV/AIDS

HIV/AIDS is one of the causes for the high attrition rate of personnel from the health sector. In addition, it has increased the demand for health care in such a way that it has resulted in the displacement of some health services. Hospital-based studies have shown that HIV-related conditions account for 40% of all in-patient admissions, possibly crowding out the delivery of other services.

The increasing funding, energy and attention being paid to HIV/AIDS services, in particular antiretroviral therapy (ART), is resulting in a relative de-prioritisation of other health policies and services. The GFATM requirements for quick outcomes and performance-based funding have introduced an enormous pressure to reach annual targets. Where health services are

currently understaffed and struggling to provide existing services, the introduction of new services for HIV/AIDS cannot be seen as additional, but will be at the expense of some other service area. Although there has been additional funding to support the expansion of ART, the funding will not translate into the required expansion of health personnel because of the lack of supply and the inadequate allocation of AIDS-related funding to health personnel salaries.

Because of the urgent imperative to expand access to treatment, funds earmarked for ART may also result in a reliance on the private and non-government sector, which in turn may accentuate the internal brain drain of staff from the public sector, as well as further increase the public sector's burden of having to better coordinate activities in the health sector.

What is particularly worrying is that the burden of addressing HIV/AIDS is not as great now as it was in the 1990s when the MMR was lower.

Underlying factors

Economic and political context

The state of health in Malawi is inextricably linked to the state of poverty and socio-economic development. Poverty impacts on Malawi's maternal health status at the individual, household and health systems level through a number of pathways. At the household level, poverty constrains access to health facilities and the consumption of health care. At the health systems level, health expenditure falls far short of that required to finance a minimum essential package of health services and to adequately remunerate health personnel. At the country level, Malawi is vulnerable to the loss of its few skilled health workers to richer countries and is unable to adequately fund its education sector. Its dependence on donor funding undermines the development of strong local leadership in the health sector and leaves Malawi susceptible to the effects of multiple and fragmented donor and non-government projects.

Macro-economic factors and broader development policies are therefore critical to any effort to improve maternal health. Understanding why Malawi is so poor and what can be done to lift the country out of its current levels of poverty must be taken up as a challenge by anyone with an interest in Malawi's Millennium Development Goal health targets.

Some of the issues that need to be considered include the declining terms of trade of Malawi's primary exports, the effect of global economic liberalisation undermining the nurturing of local economic development and the inadequate relief of Malawi's unjust debt burden.

Sectoral policies

As highlighted earlier, a number of factors outside the health care sector, such as female education and literacy, have an important bearing on maternal health outcomes. In terms of education, there has been some progress made in increasing the enrolment of girls in primary and secondary schools, which will bring important health dividends in the future. However, in real terms, budgets in the education sector (and other social development sectors) remain just as inadequate as they are in the health sector, and equally dependent on overseas aid.



Another important policy issue is the lack of household food security, which contributes to both poverty and poor health. Apart from the problems described earlier, the decimation of the agricultural labour force by HIV/AIDS and raised household dependency

ratios underlie a perilous and chronic state of household food insecurity, exemplified by the food crisis of 2002, which was precipitated by a drought. The maternal mortality audit conducted in the Southern Region was of deaths that occurred in 2001. It is possible that an audit of deaths in 2002, during and after the food crisis, might have shown an even higher number of deaths due to delayed access in seeking care as households struggled to maintain food on their tables.

The development of roads, transport and telecommunications are other areas of public policy that affect maternal health outcomes.

This paper does not provide a detailed analysis of all the factors underlying Malawi's maternal health. What is important is that Malawi's high MMR is viewed as a consequence of factors operating at a variety of levels (the household, clinic, hospital, district, country and global levels), as well as a mix of clinical, biological, environmental, social, cultural, political and economic factors. For more detail, the full version of this paper is available at <http://www.hst.org.za> or <http://www.gega.org.za>.

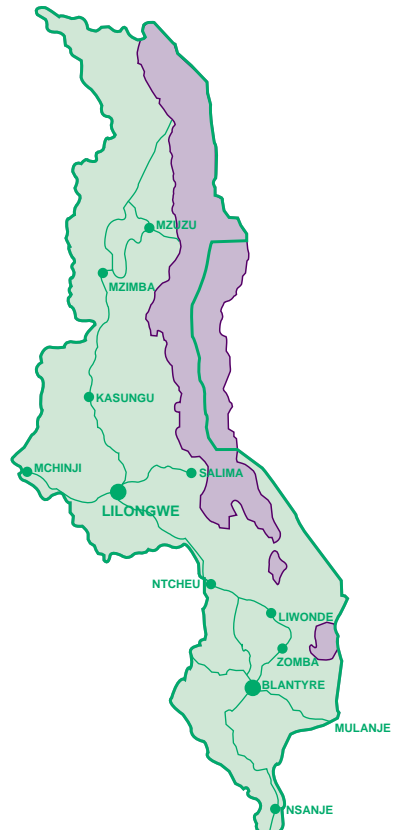
DISCUSSION

The large majority of maternal deaths in Malawi are preventable through basic, tried and tested obstetric health care services. Even if a significant proportion of the maternal deaths are due to AIDS, good basic medical care as well as treatment with modestly priced antiretrovirals, should allow a much lower MMR in Malawi. The scale of the health systems deficiencies in delivering these services suggests that the deplorable doubling of maternal mortality is as much a crisis of the entire health system as it is a crisis of maternal health services. Malawi's entire health system has been in a state of progressive deterioration over the past two decades due to chronic under-investment, structural adjustment programmes and the gradual attrition of health personnel. An integrated health systems approach to maternal health development is clearly necessary.

It is suggested that this would imply five things:

- 1) A shift in mindset to recognise the fundamental importance of the health system to health outcomes, and the need for coordinated, sector-wide leadership;
- 2) A national and international commitment to the full and uncompromised financial and human capacity to deliver essential health care services for all;
- 3) Appropriate health systems development policies;
- 4) Effective human resource management and development; and
- 5) District Health Systems (DHS) development.

These requirements are discussed in more detail in the full version of this document.



RECOMMENDATIONS

These recommendations are organised in respect of the various role-players considered to be important for reducing Malawi's maternal mortality, and doing so in an equitable manner.

1. Government of Malawi/Ministry of Health

Sector-wide leadership

- 1.1 The government of Malawi should provide unambiguous and clear leadership in a programme of comprehensive health systems development. The recent Sector-Wide Approach (SWAp) to health development should be conceived of as an opportunity to provide more integrated and coherent health sector leadership, but it will still require the government to make clear statements of principle to guide the process.

This should include upholding the principle of inclusive public health systems that allow the equitable distribution of health care resources, as well as opportunities from risk pooling and cross-subsidisation. It should also entail a commitment to ethical governance and the zero tolerance of corruption, starting from the top and working down.

- 1.2 The government of Malawi should provide leadership around the improvement of women's social and health status by declaring the high rates of maternal mortality a social and public health priority and fostering a culture of equal rights between men and women.

Health systems development, not health sector reform

- 1.3 The proposed agenda of health sector reform which appears to encourage privatisation, cost-sharing, outsourcing and the fragmentation of the health system carries serious threats to worsening inequities, undermining the public health system and creating market-led inefficiencies. These should be resisted, at the very least until there is a greater degree of public sector capacity to effectively manage the reforms and provide effective sector-wide oversight and regulation to the private and public health systems. Instead, there should be a programme of health systems development focused on the following:

- 1.3.1 A comprehensive, holistic and properly funded HR strategic plan that addresses the inadequate numbers of skilled staff, the inequitable distribution of staff, the high levels of demoralisation and demotivation, the high rates of staff attrition,

and the uncoordinated post-basic and in-service training activities must be a central priority of the country's health systems development agenda. This should include an emphasis on the recruitment and retention of skilled doctors and skilled birth attendants.

- 1.3.2 A programme to establish a District Health System (DHS), whereby the health system is organised geographically and district health management structures provide the foundation for more locally relevant, bottom-up planning; the functional integration of government and non-government providers; and the coordination of multiple health initiatives within a single and coherent district health plan. This would require building into the HR plan, a strategy to deconcentrate senior and experienced health personnel to the level of the district, and reorientating the role of central officials to one that is focussed on policy development, facilitation and providing support.
- 1.3.3 A needs-based resource allocation formula (within the organisational framework of the DHS) that takes into account all the major streams of government and donor health financing. This should be coupled with the development of clear and explicit staffing norms (based on population and an index of need) for each district, so that progress towards the equitable distribution of health personnel can be monitored and tracked. From the perspective of maternal health, resource allocation planning should also incorporate plans to reach WHO standards on the availability of and access to basic and comprehensive emergency obstetric care.
- 1.3.4 A rational, equitable and cost-effective pattern of health expenditure across the different tiers of the health system. This implies some shifting of resources from urban and tertiary facilities to rural and primary level facilities.
- 1.3.5 A comprehensive and coherent plan for the strengthening and improvement of sector-wide support systems related to the supply of medicines, equipment and blood; health information (focusing on human capacity to collect and interpret data); transport and telecommunications; and human resource administration.

Maternal health programme interventions

- 1.4 Within a broader health systems development agenda, the following recommendations should also be pursued:
 - 1.4.1 Strengthen the capacity of supportive supervision for maternal and reproductive health services at the district level.

- 1.4.2 Strengthen the collection and analysis of data from perinatal and maternal mortality surveillance systems, and establish regular four to six weekly perinatal and maternal mortality audits on a district by district basis.
- 1.4.3 Strengthen existing Information, Education and Communication (IEC) programmes targeting the community and public on maternal health as well as family planning and women's rights.
- 1.4.4 Encourage and support the development and use of maternity waiting homes, as well as of transport and telecommunication systems to reduce barriers to care and enable the referral system to work.
- 1.4.5 Legalise the termination of pregnancy

Addressing poverty and the underlying determinants of poor health

- 1.5 The Poverty Reduction Strategy (PRS) of Malawi must be highlighted as an important vehicle for addressing Malawi's maternal health problems, by virtue of its effects on nutrition, household income, food security and education. As with the development of the health sector, the government needs to take greater leadership over the process in a way that is principled, transparent and aligned to principles of ethical governance and equity
- 1.6 Concerns that the thrust of Malawi's current PRS is over-emphasising economic growth and liberalisation at the expense of social security safety nets and the creation of assets for the poor to allow them participate in economic self-development must be taken up. The role of the state to ensure the provision of basic household needs must not be diluted through the process of reforms being promoted through the PRS.
- 1.7 From the perspective of maternal health, there needs to be a greater emphasis on raising levels of female literacy.

2. Donors and development community in Malawi

- 2.1 It is first of all hoped that the donor community will support the recommendations listed above for the government/MoH. Their commitment to a SWAp is an encouraging first step. However, much more needs to be done to ensure that the SWAp translates into the reality of donors and development partners sitting in the same boat and rowing in the same direction. This would include explicitly supporting the need for root and branch health systems development, adequate health systems resourcing and the adoption of a culture of bottom-up problem solving, rather than the top-down implementation of blueprint solutions.

- 2.2 In addition to supporting the recommendations listed above, donors also need to consider the development of a code of conduct that would lay down principles around their obligations to ensure donor harmonisation, avoid burdensome red-tape and promote equitable and appropriate schedules for consultant fees and technical assistance contracts. Among other things, they should be advocating for countries as poor as Malawi to benefit from unambiguous and long-term funding support to meet the basic recurrent costs of the health system, and from deeper and faster cancellations of its debt burden.

3. Non-profit sector in Malawi

- 3.1 The mission facilities and NGOs that provide health care in Malawi are a vital and important component of the health system. The role of the non-profit private sector must be clearly distinguished from the commercial and for-profit private sector in formulating health systems development strategies by the government. The non-profit private sector on the other hand should support the idea of a proper and effective DHS within which cooperation, policy coherence coordination and appropriate partnerships with the public sector can evolve and develop. They should also be prepared to participate in national health accounts exercises and proposals to develop equitable and integrated resource allocation strategies.

4. Global health institutions

- 4.1 In addition to supporting the recommendations listed above, it will be necessary also for the primary global health institutions such as the WHO and UNICEF, to take up the macro-economic determinants of Malawi's chronic poverty and health systems under-resourcing with much greater vigour and courage. The line between Malawi's deteriorating maternal health status and rising HIV/AIDS epidemic and the unfair global political economy must be drawn more boldly.
- 4.2 At the same time, global health institutions such as the WHO and UNICEF should be charged with the responsibility of monitoring the role of the World Bank and IMF in encouraging health sector reforms that threaten to aggravate inequities and diminish the role and capacity of the public sector to provide adequate health sector stewardship.
- 4.3 The problem of the global brain drain is receiving greater public attention, but more visible signs of innovative and bold solutions to meeting this problem should be encouraged. Considerations of raising money directly (e.g. through various forms of international levies and taxes) at the international level for a Global Fund for Health

Systems development should be proposed if the international market in health personnel is to become progressively globalised.

5. G8/OECD governments and public

- 5.1 The unwillingness of the richer countries to promote a fairer and more just global political economy, to cancel the 'odious debt' of countries like Malawi and to reach the target of 0.7% of GDP must be condemned, and identified as one of the reasons for the poor health outcomes in Malawi. It is recommended that the public health community in these countries play a more pro-active role in influencing their respective governments to do more.





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