Interview

Dr Giovanni Putoto, Head of Planning, Doctors with Africa CUAMM

Giovanni Putoto is the Head of Planning at Doctors with Africa CUAMM. The organisation provides obstetric care in 15 hospitals and districts of seven African countries. In 2011, Doctors with Africa CUAMM staff assisted the delivery of more than 30 000 babies. It has recently launched a multi-country program to ensure 'free access to safe delivery and neonatal care' in Angola, Ethiopia, Tanzania and Uganda, aimed at providing 125 000 assisted deliveries.

What are the critical aspects of maternal healthcare and how does this apply to Africa specifically?

Maternal mortality in Africa, specifically sub-Saharan Africa, carries the heaviest burden of global maternal mortality. In 2010 it is estimated that out of the 287,000 global annual maternal

deaths, 56% occur in sub-Saharan Africa, yet the region has only 11% of the world's population.

Maternal mortality ratio in some sub-Saharan countries where Doctors with Africa CUAMM works (e.g. Sierra Leone, South Sudan) can be very high, around or more than 1000 per 100 000 live births.

Spending some time in rural districts in Africa would help us to comprehend these unacceptable statistics. Rundown health hospitals, lacking safe water supplies and medical equipment for emergency obstetric care; over-crowded, yet understaffed, delivery rooms; poor communication and reporting systems, are all too common. Add to this the long distance, unbearable costs for transport and user fees and deeply rooted cultural habits, it then becomes clear why the majority of women still deliver at home, unattended. This context helps to explain why coverage by skilled birth attendants is still very low and why inequity in access to good quality care between and within urban and rural communities is so widespread. *In the end, dysfunctional health systems, that are unable to scale up the delivery of effective health packages, are the main critical aspect of maternal healthcare.* The main underlying factors are chronic underinvestment in health system strengthening in general, and in health workforce development in particular. In Ethiopia, for instance, there is one midwife per 20 000 deliveries on average; the ratio could be even worse in

hard to reach and hard to stay areas.

What are the major causes – how big are these problems?

Around three quarters of maternal deaths in Africa are due to direct obstetric complications, which occur around the time of childbirth: haemorrhage, hypertensive disease, sepsis/infection, prolonged labour and abortion. Non-pregnancy related infections, such as HIV/AIDS, TB, malaria and other diseases, account for the rest of deaths, depending on local epidemiology. Maternal undernutrition is a risk factor for poor maternal, newborn and child health outcomes. Most obstetric complications are unpredictable, but, if recognised and properly referred, can be treated successfully. That is not easy in practice. Mothers' lives cannot be saved by any one intervention alone: maternal mortality reduction requires a health-system solution as illustrated by the three delays model. The first one is the delay in the decision to seek care which may be due to a lack of understanding of complications, acceptance of maternal death, low status of women and socio-cultural barriers to seeking care. The second one is the delay in reaching care which could be due to factors such as poor terrain, lack of transport means and long distance to the place of care. Once the woman has made it to the health facility, she is exposed to a delay in receiving appropriate care which could be due to lack of supplies and/or personnel, poorly

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trained personnel and lack of money to pay for the service. The result of these delays is low coverage of, and inequities in, access to life saving health interventions, and poor quality of care.

Social determinants play a key role in access to, and the utilization of, maternal health services. Armed conflicts in some African countries have also impacted greatly on maternal health in the affected countries.

To what does this expose the child?

Foetal and neonatal outcomes are greatly affected by the health of the mother. Maternal nutrition, in this respect, is important. But health services also play a key role. About 50% of still births and 25% of neonatal deaths are strictly related to access to quality care provided to the mothers during the intrapartum phase. This means that the care to reduce maternal deaths is also crucial for the survival and health of the foetuses and new born. It is one more reason to address the gaps of the system.

Is maternal health perceived to be a priority in Africa?

On paper, yes. African governments seem to perceive maternal health to be an area of priority. In 2005, recognizing that African countries are not likely to achieve the Millennium Development Goals (MDG) without significant improvements in the sexual and reproductive health (SRH) of the people, the African Ministers of Health adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights, which was endorsed by African Union (AU) Heads of State in January 2006. The policy calls for strengthening of the health sector component by increasing resource allocation to health, mainstreaming gender issues into

socio-economic development programmes, and positioning SRH among the highest six priorities areas of the health sector. To operationalize the continental policy, AU Ministers of Health endorsed the famous Maputo Plan of Action the goal of which is 'to ensure effective implementation of the continental policy including universal access to SRH by 2015 in all countries in Africa. African countries, with support from the WHO, UNICEF and UNFPA, began developing national Road Maps for accelerated reduction in maternal and new-born deaths. In 2008/2009, a review of 33 African countries' progress in developing and implementing these Road Maps found that, generally, there was a lack of national commitment to the plans. There was a low level of financing of health services, poor management of essential supplies and medicines, and a chronic shortage of human resources. This lack of commitment, in a practical sense, by African states does not apply only to maternal health; in fact, it applies to the entire health sector. A good example of this is the 2001 Abuja declaration whereby African leaders pledged to allocate at least 15% of their annual budgets to the health sector. However, in 2007, 19 African countries allocated a lower proportion of their national budgets to health than they did before the Abuja declaration. Only a handful of countries (Botswana, Madagascar, Tanzania and Liberia) honoured the declaration.

What emphasis are charities and medical and humanitarian aid organisations placing on strategies to overcome the problems?

Humanitarian aid organizations are working to support governments in addressing

maternal health care as a priority. However, the humanitarian 'babele' is often fragmented and the proposed interventions are sought to cover only vertical intervention: HIV/AIDS prevention through PMTCT, TB control projects, vesicovaginal fistula, just to mention a few. By doing this the health system, particularly at district level, has been weakened still, rather than strengthened. In 2008, the WHO Report again brought special attention to the primary health care (Primary Health Care: more than ever). It showed that the maternal mortality reduction is significantly linked with overall health system strengthening. Moreover, it offers a great opportunity to integrate interventions to control HIV, TB and Malaria. Integrating reproductive health and control of infectious disease programs is today a new frontier for many implementing agencies working in the field. Not a promenade, of course, but experiences show that it can yield cost effective results.

Somalia's mortality rates are twice the global average – in a country with continuous civil war and cyclical drought, is this a particular concerning case amongst sub-Saharan African countries?

People, particularly pregnant women and children, living in a fragile country, like Somalia, are very vulnerable to avoidable deaths and diseases. But, who is taking care of them? Humanitarian engagement with armed non-state actors would be necessary if we want to provide protection and assistance to these people, yet this is not done. Dialogue with local communities and armed non-state actors is hampered by political, legal and financial barriers. UN agencies are no longer taking the lead in this area. The humanitarian space

in Somalia is said to be a 'scarce commodity', and, as a consequence, people continue to suffer.

WHO have reported that mortality rates dropped 50% in the period between 1990 and 2010, and fairly consistently across sub-Saharan Africa too. What strategy changes have caused this improvement and how widespread are the interventions?

With respect to MDG 5, in sub-Saharan Africa the situation is quite differentiated: there are few countries on track, some have made progress (though insufficient to reach the targets by 2015) while others are still lagging behind. For those countries that have shown progress in reducing maternal mortality, there was a mix of strategy changes. There was a focus on the policies that were achieving better coverage (number of anti-natal clinic (ANC) visits, births attended by skilled health personnel, access to basic and comprehensive emergency obstetric care) and on improving the quality of maternal health services. In the field of health financing, it is worth mentioning the effect of policies introducing free care for maternal services, although with mixed results. Currently, there is a lot of interest in incentives, e.g. pay for performance to reward health staff, and voucher programs for transport and maternal services to sustain the demand of maternal care. On the side of Human Resources for Health, important steps were taken to implement innovative measures to fill the gaps of qualified health staff such as task-shifting approaches – community-based interventions and non-physician clinicians – and more emphasis on skills-oriented training and education.

As for donors agencies, the maternal and child mortality indicators that were widely utilized in evaluating the country health performance, and the budget allocation for maternal and child health intervention, were strictly monitored by supporting donors. Performance disciplines, result-based reporting mechanisms and problem-solving attitudes also contributed substantially. These strategy changes were made possible because of strong government leadership and effective coordination action among all stakeholders, including civil society, faith-based organisations and professional health bodies. Perhaps all this could explain why some African countries, despite adopting the same policies, have made progress while others have not. Context matters.

How accurate are maternal health morbidity statistics?

The current statistical methods to estimate maternal mortality are secondary data based on periodic surveys. They are estimates that use statistical models to predict values for countries and/or time periods for which empirical data are not available. As such they are partially accurate and sometimes, because of different statistical techniques used, they give rise to different results. Add to this the fact that counting of the real number of maternal deaths is not happening, then we have what is known as 'the scandal of invisibility'; vulnerable people and poor communities are neglected when it comes to their health and survival. To be really effective, we should invest more in vital statistics, using timely and reliable primary data such as births, deaths and cause of deaths. We have known this for a long time. It is time to act.

What would be an effective approach to maternal health and morbidity/mortality?

Continuum of care approach is the approach suggested in the Global Strategy for Women's and Children's Health. Women should have access to an effective health care package according to the time (from pre-pregnancy, through pregnancy, childbirth, and the early days and years of life) and level of care (from home/communities to primary and secondary health care facilities). However, scaling up access to all these interventions at once is not always feasible and there is, therefore, a need to select a set of interventions and prioritise their delivery depending on the health system context. Improving the health delivery system is just one step, a major one. But it is not enough. Addressing the social determinants of maternal health is also inevitable in reducing maternal mortality and morbidity. In this respect strategies, such as targeting poor women and support them, improving access to education, working towards gender empowerment and making equitable resource allocations, are also important aspects to consider.

What elements of maternal health do you believe deserve more attention?

Since most maternal, stillbirths and neonatal deaths occur around the intrapartum period and immediately after delivery, ensuring that women have access to a skilled birth attendant at delivery and to facilities for treating and managing delivery complications, is very critical. Efforts should therefore be made to remove all barriers of access to these lifesaving interventions and ensure universal access to delivery services. In line with this, investment in operational research and IC

technology (i.e. use of mobile health devices) for maternal health is an area that deserves a close look.

How much per 1000 inhabitants would it cost to provide satisfactory intrapartum attendance in sub-Saharan Africa, and is this affordable?

Yes, it is affordable. The Stillbirths Series (*Lancet*, 2011) emphasises the critical nature of the intrapartum period as a narrow window for intervention, when nearly half of stillbirths,

three quarters of maternal deaths, and one quarter of newborn deaths occur (totalling 2.3 million deaths). Robert Pattinson *et al.*'s paper in this series outlines the costs of an effective health care package that incorporates comprehensive emergency obstetric care:

'If all women gave birth in health facilities offering high-quality comprehensive emergency obstetric care, 27% (696 000) of stillbirths, 46% (171 000) of maternal deaths, and 18% (591 000) of neonatal

deaths could be averted. Childbirth care is an expensive package at a total additional cost of just under \$4 billion, but has the biggest effect on the number of deaths, with a cost per death averted of \$2708, and a cost per person of just \$0.84'¹

Figures such as these show why advocates across all of women's and children's health should rally together to count and address stillbirth, maternal and new born health all together and ensure integration of these issues into the continuum of care.

¹ Source: Stillbirths: how can health systems deliver for mothers and babies? Robert Pattinson, Kate Kerber, Eckhart Buchmann, Ingrid K Friberg, Maria Belizan, Sonia Lansky, Eva Weissman, Matthews Mathai, Igor Rudan, Neff Walker, Joy E Lawn, for The Lancet's Stillbirths Series steering committee: <http://www.thelancet.com/> Published online April 14, 2011. DOI: 10.1016/S0140-6736(10)62306-9.