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ORGANIZING TO MEET CRITICAL NEEDS FOR MATERNITY CARE IN DEVELOPING COUNTRIES: A SOCIAL AND HEALTH SYSTEM DIAGNOSIS

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Abstract

The sustainable development goals (SDGs) targets for improving adequate and respectful sexual and reproductive health outcomes will rely on how efficient health systems are organized to deliver these essential services. Beyond maternity and reproductive health outcomes, an efficient diagnosis of social and health system challenges across most developing countries could help improve general health service delivery. We aim here to provide an overview of health system level issues that need urgent context policy level consideration. To attain this, we set out to assess at social and health system level, issues that need attention to improve women health outcomes. We advocate specifically for health systems to be designed around meeting patient-value based health need, providing options for patient payments systems in order to guarantee sustainable health systems whiles improving skilled provider care for maternity care. Beyond 2015, there is need for country long term financial planning and the generation of reliable health data that helps in health prioritization and planning for advancing long term prospects of maternity care across most developing countries.

Keywords: maternity care, critical need, Developing countries, social, health system.

Introduction

An estimated 10.7 million women died worldwide from maternal causes between 1990-2015 [1]. Globally, women in developing countries bear a disproportionate large share of the global burden of disease and death outcomes [2]. More than one-third of all pregnancies in developing countries are considered unintended with an estimated 19% resorting to abortion [3, 4]. Unmet needs for contraception remains problematic [5, 6]. Admittedly, Sub-Saharan Africa (SSA) remains a least region with higher levels of lifetime risk for maternal deaths globally [1]. Poor and inadequate access to a long life maternal care plan that meets each woman's reproductive health need often accounts for this. Many developing

countries health systems remain poorly funded [7-9]. Economic driven changes through structural adjustment programmes (SAPs) in the 1980s did not affect improvements in health systems in most developing countries [2]. Health systems are poorly designed (physical & operational) for delivering effective care services [2].

Within and across countries, health systems are traditionally more clinic-oriented, populated in urban areas with high ratios of skilled workforce [2, 8]. Health systems also tend to be more physician-oriented and absent predominantly in rural populations where access is already poor [2, 10]. Additionally, low service utilization is attributed to user's unbalanced perceptions of the poor quality and social support available to them [11]. Poor provider relational issues, often attributed to a health arrangement where patients have *no right of say* during diagnosis exist. Evidence of contextual factors as major drivers of maternity and reproductive health care is proven in developing countries [12-14]. Economic differences mediated by four main drivers; income level, residence (urban, rural), autonomy and employment status impacts on maternity service utilization.

More importantly, educational status, ethnic, cultural and social group norms suggest a much broad influence on women's health [15]. In Bangladesh, investing in girl's education to at least secondary level provides a window of opportunity for them to effectively manage maternal complications later in life [16]. Likewise, in Malawi, health providers awareness and incorporation of traditional belief systems helped improve women maternity care [2]. These two cases from Bangladesh and Malawi suggest looking beyond health system factors into social and economic drivers has a positive trigger to good health outcomes for women.

This brief provides useful lessons that have led to improvements in maternity care across developing countries. It aim to contribute to the need for paradigm shifts to delivery maternity care, incorporating context novel approaches that creates value based care needs for better health outcomes.

Health reforms needs for service delivery

Health reforms in most developing countries such as fee exemptions are characterized by vertical programs that only manage routine service delivery conditions [17]. A health reform as defined in *by data for decision-making (DDM, 1995) refers to a* ***sustained, purposeful and fundamental change****" to health care delivery [18]*. Developing countries that have been able to undergo strong health reform changes have experienced positive effects on maternal healthcare [8]. Contrary, empirical evidence shows some reforms can produce negative impacts on maternity care if not well implemented [19]. Best impacts are noticed in health systems that incorporate decentralization of health administration, financial reforms and funding diversification whiles integrating service delivery components. User fees remain predominantly the major mode of individual healthcare financing in developing countries [20]. Evidence of this potential effect on declining use of health services is documented [20]. In most developing countries where men have *monopoly* to take economic and health decisions, women access to health care further worsens where male support is absent [21]. Whiles evidence in countries such as Ghana, Uganda and Bangladesh show positive maternity service utilization in the absence of direct fees for maternity care [8], user fee removal may not essentially improve maternal care utilization. In some instances, informal payments are often higher than approved user fees [8]. Most vertical programs such as free fee exemptions have often been

problematic with transport and referral problems to care [9, 22]. Cambodia and Nepal provides evidence of countries where reforms such as transport cost and time if well-organized can improve women maternity service utilization in a developing context [1, 23]. To make health reform improvements across all country contexts, ensuring universal health coverage (UHC) is important. A first step to ensuring UHC is for developing suitable health funding schemes. For countries with current social health insurance schemes, the need to improve these schemes to broaden the basic benefit packages across many vulnerable population groups is important. Additionally, patient payment systems and value based cost sharing options for delivery health services are important.

In addition, health system changes have affected little skilled provider numbers for maternity care[24]. Inadequate or non-existent health infrastructure, lack of emergency obstetric care and safe abortion needs, limited medical diagnostics; non-existent laboratory services characterize most health delivery systems for women[7]. Unsafe abortions still exacts a toll of maternal deaths across 75 developing countries [25]. Lifesaving surgery for obstetric care is low, as the overall caesarean birth rate for developing countries stands at 3.5% (excludes china)[26]. Non-state actors have played a major contributory role to service delivery in most developing countries. Private health facilities contribute substantially for health service delivery[27]. An estimated 23% of South Africans had private insurance with an estimated 60% of its GDP expenditure on health occurring in the private sector[27]. Although these health facilities are often small with limited capacities, they provide an alternative to the perceived poor quality and social support and drug shortages often cited in most public health facilities in developing countries. Inequities however exist within the social strata in any country for the available private health care. Wealthy and urban areas are better served. Challenges remain huge on this potential due to emergence of *quack physicians and* self-professed medical professionals. Meeting skilled care professional numbers in many countries require governments' prioritization to train a cadre of workforce over a period of time. Health reform targeting long term financial planning and commitments are useful, to avert funding-stop gaps for most vertical programs. Along with training, the health system ability to continually train and retain skilled professionals is important. Health systems must also design robust monitoring and accountability systems that check loses that divest health system's ability to offer equitable, access to quality services. Aside skilled professional care attendants trained and often times untrained Traditional Birth Attendants (TBAs) still remain the only first line of support for deprived rural women in some developing countries. In Ghana, however, new health sector policies are shifting the role of TBAs to provide referral support for women travelling to the facility level to seek maternity care. Across other countries in Africa, TBAs remain instrumental for meeting maternity care needs [28-30].

In most developing countries, trained TBAs will remain critical for meeting short term skilled shortages for maternity care. There is the need to improve the capacities of TBAs to offer task shifting support in periods of emergencies. Furthermore, their roles in meeting health advocacy and follow-up monitoring for women with adverse pregnancy complications prior to delivery will be important. The challenge of inadequate training and skills support to these TBAs often does not deter these women who seek care since they perceive TBAs to be more socially supportive. The

critical role of the private sector to health delivery in developing countries will remain important for a long time to come. Health system arrangements and reforms that regulate their space and provide a good window of public-private partnership to delivery patient centered care will enhance maternity health outcomes in most countries.

Global achievements and post-2015

The safe motherhood conference in 1987 in Nairobi, Kenya, to galvanize support and commitment to address women health needs, followed by the International Conference on Population and development in 1994 in Cairo saw the advancement of rights based approaches to meeting women health and development needs[31]. Subsequent high level meetings such as the Beijing conference of women in 1995 and the 1997 safe motherhood technical consultation meetings reemphasized national and global efforts to improving maternity and reproductive health outcomes. However, the adoption of the MDGs in 2000 by more than 170 countries draw a new wave of global support to measure and track real progress on women health issues. Results have been mixed after 15 years. The greatest burden of deaths still occurs in developing countries. Nevertheless, global maternal mortality rates (MMR) dropped from 385 deaths per 100,000 to 216 deaths per 100,000 between 1990-2015[1]. Progress however on these indices differs within and across regions. The highest MMR declined occurred in eastern Asia from 1990-2015. MMR is also evidenced to range between 12 deaths (developed regions) per 100,000 to 546 per 100,000 in SSA [1]. SSA recorded the highest MMR decline in 2015. Eight countries; Guinea, Central African Republic, South Sudan, Chad, Liberia, Nigeria, Sierra Leone, and Democratic Republic of Congo MMR exceeds 500 per 100,000, showing slow progress to MMR in these areas [1]. MMR of 5 or less per 100,000 was evidenced in Finland, Greece, Poland, Iceland, Kuwait, Sweden, Austria, Belarus, Czech Republic and Italy [1]. At the global level, lifetime risk of maternal deaths fell more than half in 2015 and ranged between I deaths per 23700 women (18000-32700) in Greece to 1 death per 17 in Sierra Leone[1]. Consequently, critical interventions for maternity and reproductive care improved over the last one and half decade. Point estimates from recent evidence shows improvements in antenatal care (ANC) coverages, demand satisfied for family planning, effective control of malaria in pregnancy in endemic areas, vitamin supplementation, improvements in skilled care at birth and effective vaccination for better maternal and neonatal outcomes have been evidenced at the MGDs rea [25].

Although these changes does not appear even across countries, it proves proven interventions exist on good maternity health outcomes. ANC (at least one visit) and three indicators of vaccination coverage recorded sustained 80% coverage. In all regions and countries were these improvements have occurred, health system changes resulting in available health workforce numbers, access to care and functioning funding schemes exist. Evidence on maternal deaths reductions attributed to contraceptive use exists [32]. Social and economic changes resulting in small family size are also evident in SSA, although the greatest fertility declines within developing countries appears in Eastern Asia[3]. In 2012, three out of four women wanting to avoid pregnancy used modern contraception, with a slight decrease in unmet need levels in developing countries[3]. Novel approaches and evidence in Zambia proved well trained community health workers can play a key role in making family planning services readily available to underserved populations. Considering the enormity of population surge faced by most developing

countries, policies that continually improve family planning access, improve method choices for users and the provision of accurate information and confidentiality remain important to reduce further unmet need levels.

Professionalization in skilled care provision has arguably be recognized and prioritized in most health system reforms in developing countries. Skilled care before, during and after childbirth has improved [33]. In many low middle income countries, user expectations on quality and safe care during pregnancy and childbirth exist [10]. Recent midwifery advancements that combine both technical and family planning interventions along the continuum of care are increasingly adopted [10]. However, meeting the challenge of health workforce shortages, brain drain syndrome and tackling unqualified health professionals in the provision of care exist [24, 34], yet offers opportunity for more efforts in post-2015 agenda.

Policy implications for maternity beyond post-2015

Proven strategies for advancing maternity and reproductive health exist [1, 35, 36]. Public investments in maternal health yields multiple health and social benefits [23]. The need for vital data systems to plan and prioritize, expansion of health coverages with performance reward packages for health staff, increasing skilled provider ratios and the provision of comprehensive community based health schemes are possible in developing countries. What remains is political commitment. Countries must however decide on their local context first, to make progressive change. Globally, more efforts to mobilizing financial resources, documenting evidence-based strategies, developing targets and indicators, monitoring and enforcing progress towards improvements in maternity and reproductive health in developing countries is important.

To improve health service delivery, reliable and consistent data gathering and use is important [7]. Vital registration systems are absent in most developing countries [1]. This affects health prioritization, planning and resource allocation. Urgent health system and funding arrangements that makes data gathering is needed to improve health systems in developing countries [7, 25]. Demographic and health surveys (DHS) data remain a reliable data tool for policy and health planning in most developing countries. Recent review evidence in West Africa on reproductive health outcomes shows context measures to measure progress is important [37]. Poor economic outcomes manifested in poor health infrastructure, poor access road networks, poor commitment to health funding and a good collaboration between the public and private sector are essential to produce a good healthcare market. Undoubtedly, local multisector approach and resource commitment to context evidence based data is important.

Conclusions

Evidence to advance better maternity care outcomes is widely known [1]. Health systems that are engineered and delivered along proven strategies are likely to accelerate women maternity outcomes in developing countries. We advocate health system shifts that looks into incorporating value based cost sharing on health services delivered. A reform that adopt and upscale performance-based payments is important to retain critical skilled professionals. Suitable patient payment modality needs to be experimented under different context. Countries must identify their context need first, before designing alternative health funding options, to ensure vulnerable groups are not excluded from maternity and other general healthcare needs. Socio-culturally, health care professional must integrate context drivers for maternity and

reproductive health needs to designing and delivering services [38, 39].

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