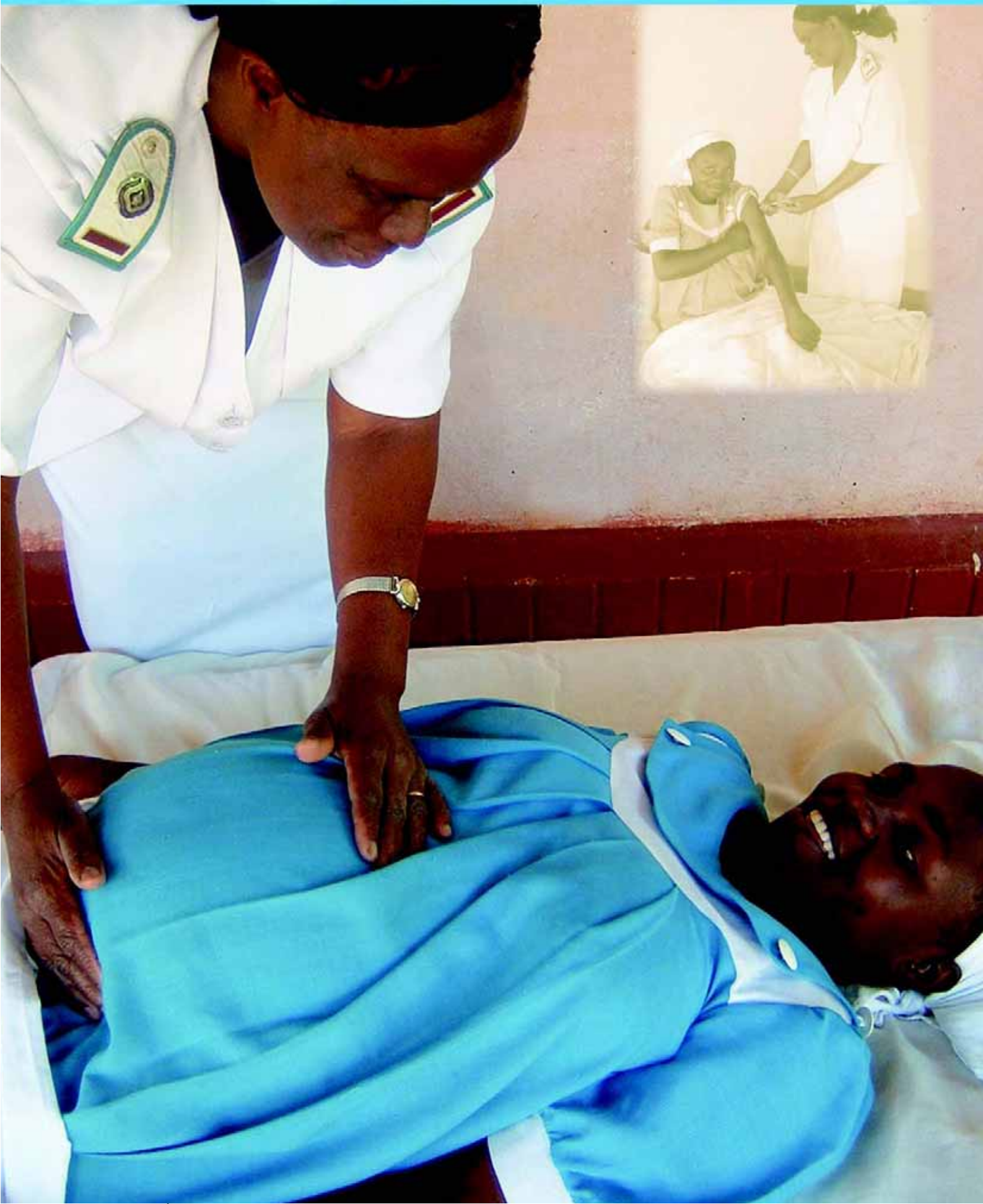
Improve Maternal Health



Improve Maternal Health

TARGET 6:

Reduce by three-quarters, between 2000 and 2015, the maternal mortality ratio.

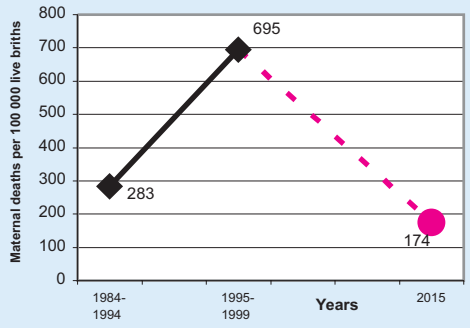
INDICATORS:

23. Maternal mortality ratio
24. Proportion of births attended by skilled health personnel

STATUS AND TRENDS

Maternal mortality continues to be a major problem in Zimbabwe. Based on estimates from the early 1980s, maternal mortality figures were estimated to be 283 deaths per 100 000 live births in 1984 -1994 rising sharply to 695 per 100 000 live births in 1995 –1999, as shown in figure 5.1. This sharp rise in maternal mortality rate is largely explained by the rapid spread of the HIV AND AIDS epidemic.

Figure 5.1: Maternal Mortality Ratios, Zimbabwe, 1994-2015.



Source: Demographic and Health Survey, Zimbabwe 1999

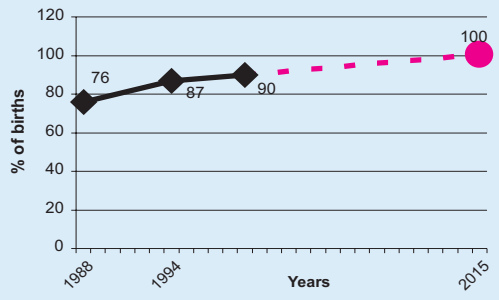
Key

- ◆ Actual
- ● Target
- Current rate of progress
- Rate of progress required to reach goal

The magnitude of maternal deaths can be reduced if mothers have access to antenatal, delivery and post-natal care. The lack of maternal care is reflected in delays in seeking medical care, receiving care, referral to an upper level hospital, and shortage of labour and essential obstetric care equipment. In addition, addressing specific maternal nutrition and diet-related problems, such as under nourishment, micro-nutrient deficiencies (iron and vitamin A) and diet related chronic diseases such as diabetes and cardiovascular disorders will go a long way in reducing maternal mortality.

According to ZDHS (1999), 72.2% of births nationally take place in health facilities. The survey states further that, 11.6% of deliveries were assisted by a doctor, 60.9% by a nurse, 17.6% by a traditional midwife and 6.3% by relatives or other people. This implies that about 90% of births were attended to by skilled health personnel (doctor, nurse or traditional birth attendant) in 1999. This is an improvement from the level of 87%[17] in 1994 and 76%[18] in 1988, as shown in figure 5.2.

Figure 5.2: Births attended to by Skilled Personnel, Zimbabwe 1988 - 2015, %



Source: Demographic and Health Survey, Zimbabwe 1999 Note: For 1988 and 1999 it is births in 5 years preceding the survey and in 1994 it is 3 years

CHALLENGES

Zimbabwe is faced with a number of challenges in the area of reducing maternal mortality. These include:

[17] Refers to live births in the three years preceding the ZDHS 1994
[18] Refers to live births in the five years preceding the ZDHS 1999

HIV and AIDS epidemic

The HIV and AIDS epidemic has placed mothers under an increased state of vulnerability. The challenge is to reverse the HIV and AIDS epidemic and mitigate its impact through the provision of antiretroviral drugs and other measures.

Essential and Emergency obstetric care services

The challenge is to mobilize both domestic resources and development assistance to ensure the availability of essential drugs and equipment necessary for the provision of high quality obstetric care.

Inadequate access to health delivery services

While health facilities in urban centres are generally within reach, in rural areas, mothers are often discouraged by the long distances they have to travel to reach a health facility. The immediate challenge is to extend primary health care facilities/clinics to rural populations.

Training and Equipping Traditional Birth Attendants

While there is need to consolidate the training of traditional birth attendants in most communal areas, the immediate challenge is to expand the programme into newly resettled areas, where health facilities are generally not available.

Addressing Maternal Malnutrition

Nutrition highlights the importance of maintaining good maternal health, given that it is generally women who sustain the food cycle from production, harvesting, storage, processing, to preparation, and consumption. In addition, issues relating to availability of local food crops, diet diversity and quality are important. Given the centrality of women in rural households, the challenge is to ensure that the nutrition of mothers is a priority at the household level.

Improving the data collection method in the maternal mortality ratio

Without an accurate measurement of the maternal mortality ratio, it will be difficult to assess the progress that the country is making in reducing mortality rates. The challenge is to develop appropriate methods of measuring maternal mortality.

Gender inequalities

Generally, in Zimbabwe, women still have limited control over their sexuality and reproductive rights. The challenge is to improve education for women and to reduce the gender inequity that prevents women from making reproductive choices.

Negative cultural practices

Culture and tradition have a significant influence on the decision to seek antenatal care. The challenge, therefore, is to empower women through IEC to enable them to make informed decisions concerning their maternal and general health issues.

SUPPORTIVE ENVIRONMENT

Although the issue of maternal health has not received as deemed necessary, the Government has put in place a number of policies and programmes in support of the goal of improving maternal health. Some of these include:

HIV and AIDS Emergency declaration

The Government has declared a state of emergency for the next five years in order to facilitate the procurement of antiretroviral and related drugs to mitigate the impact of the HIV and AIDS epidemic.

The Essential Obstetric Care Package

The Essential Obstetric Care (EOC) refers to an abbreviated list of services designed to save the lives of women with obstetric complications. The practical application of this package has a potential to lower the current maternal mortality ratio.

Free health services to pregnant women in the public sector

This programme assists women, especially the poor in both urban and rural areas, to access medical services at both prenatal and postnatal stages.

Maternity-leave with full pay

The introduction of maternity leave with full pay creates a conducive environment for the good health of mother and child.

PRIORITIES FOR DEVELOPMENT

In order to improve maternal health and well being, the following priorities need to be addressed:

HIV and AIDS

Take full advantage of the extended declaration of emergency on the HIV and AIDS infection to procure and administer antiretroviral drugs to reduce maternal mortality.

Expansion of the Essential Obstetric Care Programmes.

Mobilize both domestic resources and development assistance to ensure the availability of essential drugs and equipment necessary for the provision of high quality obstetric care.

Training of traditional midwives

Consolidate the training of traditional birth attendants with priority being given to newly resettled areas, where health facilities are generally not available.

Establishment of fully equipped referral facilities

Establish primary health care facilities/clinics in newly resettled and remote areas. At the same time, overall access to comprehensive health

delivery services should be improved for both urban and rural populations.

Addressing Maternal malnutrition

Given the centrality of women in rural households and for national food security, it is important to ensure the good health of women, in general, and for child-bearing mothers in particular.

Capacity strengthening in maternal mortality data collection and analysis

Strengthen the capacity at all levels for the collection of data and measurement of maternal health.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenge of improving maternal health are as follows:

- HIV and AIDS Emergency declaration for assistance in drug procurement.
- Expansion of Essential Obstetric Care Programmes.
- Establishment of fully equipped referral health facilities.
- Capacity strengthening in skilled human resources and maternal health data collection and measurement.

COSTING THE MATERNAL HEALTH IMPROVEMENT GOAL

Overview: While many of the comments made under education are also applicable to this goal, the health sector has its own characteristics. The main one has to do with the kind of priority accorded by the household to healthy living and longer survival. Government in turn has to judge carefully how much of its health budget should be divided between preventive care and curative care. In general, allocating comparatively more funds to preventive care has a greater impact on reducing infant, Under-5 and maternal mortality. A majority of infant and child deaths are caused by not having access to clean water and, in such cases, it may be useful to spend more in the water sector. In addition, there are other preventive factors, such as better education for mothers that help to reduce child mortality. It suggests therefore, that attaining certain health targets will require not just spending in the health sector alone, but also spending in other sectors such as water and education.

Given these related factors, it makes the projecting of unit cost for the child mortality goal a complex one. It follows therefore, that the expenditure requirements for each of the sectors needs to be assessed carefully, and only by getting the mix of spending correctly will this target be achieved. Furthermore, as stated under primary education, it is important to know how the cost of treatment should be shared between the Government and Household. Additionally, given that the parent of the child has to pay part of this cost, an assessment on the income and affordability of the household should be made on a regular basis.

Unit cost on Child Mortality and projections

The Zimbabwe targets, in accordance with MDG, are to reduce;

- Infant mortality by 66%, from 65 per 1000 live births in 2000 to 22 per 1000 live births by 2015.
- Under-5(U-5) mortality by 66%, from 102 per 1000 in 2000 to 34 per 1000 by 2015.
- Maternal mortality by 75%, from 695 per 100000 in 2000 to 174 per 100000 by 2015.
- Additionally, Zimbabwe aims to improve on such input indicators as - doctors per patient, supplies per patient, bed per patient etc.

The average cost estimates are based on Budget Estimates of 2000 (Vote 16 – Health and Child Welfare) and Statistics on mortality indicators available for 2000. Both recurrent and development budget estimates of the health sector are used to derive average unit cost. Within the Health budget, 100% of preventive care services expenditure and 10% of all other expenditures are taken in calculating unit cost for the projections. Due to data limitations it is assumed that all three mortality indicators are grouped in to one unit cost. With more des-aggregated data that is reliable and more frequently available, the unit costs of each mortality goal can be estimated separately.

Given these assumptions, annual real increase in expenditure to attain the above defined goals (including 1.1% population increase), health expenditure per child/mother should increase at 3.5% per year. Average spending over the period should increase from the current level of US$ 35.4 per child /mother to US$ 46.4 per child/mother. In parallel, total health spending over the period to 2015 should be US$43.2 mn.

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"