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Review of Australia's Relationship with the Countries of Africa

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Improved Maternal, Newborn and Child Health Outcomes: How Australia Can Assist

Document summary

This brief examines how Australian aid can be used to effectively achieve improved maternal, newborn and child health outcomes in Africa. Our positions are informed by World Vision's field based program experience and research. It builds on recent submissions to AusAID in response to the agency's *Draft Framework for Development Assistance to Africa 2009 – 2016* and our submission and supplementary comments to the Joint Standing Committee on Foreign Affairs, Defence and Trade's Inquiry into Australia's relations with Africa. World Vision is committed to ensuring that our own program and advocacy work expands to support improved maternal, newborn and child health in Africa, including increasing our human resource health capacity.

This document outlines three proposals:

Proposal 1: Australian support of health worker training institutions, in particular schools of midwifery in select African countries

World Vision encourages the Australian government to provide support to strengthen in-country training and retention of healthcare workers, especially midwives in select African countries. This could be achieved through supporting reputable training institutions to expand the quantity and quality of on-site training provided to health care professionals. This has the potential to address chronic health worker shortages and highlight Australia's identity in Africa. We also encourage Australia to consider support for shorter to medium term measures to build health worker capacity such as supporting 18 month community midwife competency training programmes.

Proposal 2: Australian Support of Community Led Health Interventions in Africa

Australia could look to support more effective and systematic community involvement in health services, their planning and monitoring. This could include supporting national level civil society coalitions of maternal, newborn and child health groups or Australian NGO partner organisations to hold their governments to account for promises and budget allocations made for the delivery of key health services. It would also assist in keeping the voices of the poorest and most marginalised in the media and other popular communication channels especially prior to major elections**.**

Proposal 3: Australian Government support for the delivery of the Minimum Initial Service Package for reproductive health in crisis and protracted crisis African countries

We encourage the Australian Government to support the delivery of the Minimum Initial Service Package (MISP) for reproductive health in crisis and protracted crisis countries.[1] This could be delivered through the establishment of a long term humanitarian grant funding mechanism for protracted crisis situations to complement the current Periodic Funding Agreement mechanism designed for rapid onset emergencies.

1 Please note World Vision does not support abortive methods which may be provided to victims of sexual and gender based violence as part of the Minimum Initial Service Package

Detailed Proposal Descriptions:

Proposal 1: Australian support of health worker training institutions, in particular schools of midwifery in select African countries

World Vision Australia encourages the Australian government to provide support to strengthen in-country training and retention of healthcare workers, especially midwives in select African countries. This could be achieved by supporting reputable training institutions such as schools of midwifery in select African countries to expand the quantity and quality of on-site training provided. Evaluations of short-term training in Africa in 2000–2001 led to the strong recommendation by the WHO that training should be provided on-site as much as possible and delivered through local institutions.[2] An overview of African countries that produce the most reliable midwives is provided in Appendix 1.

Within this scheme, support should also be considered for short to medium term measures to build health worker capacity such as through supporting 18 month community midwife competency training programmes. WHO, International Confederation of Midwives (ICM) and John Hopkins University have developed 18 month competency courses that have been implemented in Afghanistan and Liberia. The course is built on established state enrolled midwifery courses, with strict criteria for entrants such as the completion of nine years full time education. They are not meant to replace three or four year midwifery courses as fully qualified midwives need to supervise community midwives. However such courses do allow an interim solution to address current health worker shortfalls particularly in fragile states. John Hopkins University is tracking the quality of training, with research results available from the Afghanistan and Liberia programs.[3]

Why midwives matter

Providing adequate support for the training of healthcare professionals, especially midwives, should be part of Australia's long term approach to maternal, newborn and child health in Africa. Most African countries have not invested enough in nurse and midwifery training schools for the last 20 years. Yet more trained, retained, supervised, and equitably distributed health workers are at the forefront of saving lives.

A 2006 WHO survey revealed that while Africa accounts for 24 per cent of the world's disease burden it has only 3 percent of the world's health workers.[4] According to the International Confederation of Midwives (ICM), of the 250,000 licensed midwives worldwide there are only 13,000 in Sub Saharan Africa.[5] A WHO 2006 report calculated that another 334,000 midwives are needed to address a global shortfall, attributed to chronic under investment and the "brain drain" to developed countries. Of this shortfall Africa has the largest relative need.[6] Without an increase in staff there is simply not enough human capacity to absorb and utilise additional funds to improve health outcomes.[7]

Skilled birth attendance is seen as a critical intervention for ensuring safe motherhood and hastening the timely delivery of emergency obstetric and newborn care when life-threatening complications

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[2] Evaluation of short-term training activities of technical divisions in the WHO African Region. Final draft. Brazzaville, World Health Organization Regional Office for Africa, 2004 cited in 2006 WHO Report *Working Together for Health* Chapter 2 available at http://www.who.int/whr/2006/06_chap2_en.pdf

[3]For research findings from Afghanistan please see http://www.jhsph.edu/bin/c/i/Afghanistan_Balanced_Scorecard.pdf

4 UNICEF, 2009 State of the World's Children Report 2009 pg. 35

5 Accessed at http://www.irinnews.org/Report.aspx?ReportId=84241

6 UNICEF, 2009 op cit. pg. 35

7 Kinfu et al, 2009. "The Health Worker Shortage in Africa: are enough physicians and nurses being trained?" in *Bulletin of the World Health Organisation 2009: 87:* pg. 225 – 230.

arise.[8] Evidence indicates that skilled midwives functioning in or very close to the community can have a drastic impact on reduction of maternal and neonatal mortality. For example, an Emergency Obstetric and Newborn Care assessment in Northern Ghana in 2005 indicated the availability of midwives had the highest protective effect on maternal deaths, reducing the case fatality rate at Health Units by 80 percent. [9]

A 2003 World Bank report also examined seven country case studies over a ten-year period and found the two key factors that contributed to improved maternal, newborn and child health outcomes to be:

- professionalising midwifery to ensure skilled attendance during childbirth, including providing training to manage complications, stabilise and refer women with more severe complications; and

- improving access to and quality of care through rural midwives with closely linked backup emergency obstetric services.[10]

Funding Options

This proposal could be supported through a combination of one or more of the following funding options:

- **Multilateral and or bi-lateral funding to select African governments as part of health care system strengthening support**
- **Collaboration with a partner donor government(s) and or UN agency (s) as part of health care system strengthening support** (see Appendix 2 for an excellent example of this in Ethiopia)
- **Australia-Africa Partnerships Facility to provide capacity building for African governments and institutions; or**

- **Through the expanded Australian – African scholarship scheme**

The Government has indicated that its support of scholarships to African countries is likely to increase from 100 to 1000 by 2012. World Vision recommends the government consider linking its expanded scholarship program with MDG 4 and 5, to focus on select African countries with high maternal and child mortality with "in country" education and training of midwives and nurses. Limited scholarships could be provided for education based in Australia, to focus on the needs of health system leadership and management, through the establishment of partnership arrangements between Australian and African midwifery schools and associations.

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8 Skilled attendance refers to a professional with midwifery skills working within an enabling environment or health system capable of delivering appropriate emergency obstetric care for all women who develop complications during childbirth. In order to save the maximum number of lives, skilled attendants need to be linked up with a larger health care system with the facilities, supplies, transport and professionals to provide emergency obstetric care when it is needed.

9 http://www.internationalmidwives.org/Portals/5/UNFPA-CM%20Midwives%20Programme%20Update%20Sept%202009.pdf

10 Koblinsky MA et al *Reducing maternal mortality: learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica and Zimbabwe* World Bank, Washington 2003, pg. ix. The report also found that reduction of costs alone does not seem to redress the lack of facility use by those most in need. In addition other factors such as lack of knowledge about the removal of cost, traditional and cultural barriers such as cultural resistance to facility births, the role of decentralisation, planning and management capacity at lower levels and how this affects maternity care.

At present a very high proportion of scholarship recipients in the health professions end up practising in developed countries. Scholarship programs can contribute to 'brain drain' problems rather than strengthening health system capacity. As a result, World Vision advises that any enhanced scholarship program to Africa focus on scholarship provision that strengthens training and retention initiatives within recipient countries.

Any program to train midwives and other health staff needs to ensure that these trainees are able to graduate to sustainable employment situations.

Candidate selection

We recommend that a selection of candidates by provincial and district health services be prioritised over centralised selection in order to strengthen health care systems at provincial levels. Evidence also illustrates that a minimum of nine years of schooling is required to ensure candidates have the literary capacity to retain essential medical knowledge. Working in the first instance to up-skill community health workers or traditional birth attendants could be appropriate in some countries.

Incentive systems

Any scheme should also be accompanied by incentive systems to ensure students are supported to study and work in African countries – and in the regions within those countries – where the need is greatest. Areas with teaching hospitals and a population that can afford to pay for health services attract more health workers than regions without such facilities or financial support.[11] Furthermore, overstaffing in urban areas can lead to underuse of skilled personnel. Paradoxically, instead of encouraging movement of staff towards rural areas, excess numbers of health professionals in urban areas often promote external "brain drain", as professionals start leaving for employment opportunities abroad.[12]

The provision of on-site in-service training and refresher courses should also be included. Rural health workers currently suffer from the effects of isolation, lack of supplies and support, irregular salaries and excessively high workloads. MDG 4 and 5 will not be reached until health workers are provided with incentives to work in places where their skills are most needed. This includes grants for transport, houses, communications, loyalty bonuses, career progression, and sustainable employment.

Funding

Given the priority need for improved maternal and child health, World Vision recommends that at least 20 percent of Australian aid to Africa should go to health and a substantial part of this to midwifery training. Research published by the WHO indicates that it costs on average 17.6 times per capita GDP to train a midwife[13] This suggests that the cost of training in relevant East African countries would be in range of A$6,000 to A$20,000 per midwife at current exchange rates. For midwives trained on the 18 month competency course we could assume the cost per midwife would be less.

Proposal 2: Australian Support of Community Led Health Interventions in Africa

[11] WHO 2006 Report *Working Together for Health* Chapter 1 available at http://www.who.int/whr/2006/06_chap1_en.pdf
[12] Ibid
[13] Verboom P, Tan-Torres Edejer T, Evans D 2006 The costs of eliminating critical shortages in human resources for health (Background paper written for the World Health Report 2006)

World Vision recommends Australia look to support more effective and systematic community involvement in health services, their planning and monitoring. This could include supporting national level civil society coalitions of maternal, newborn and child health groups or Australian NGO partner organisations to hold their governments to account for promises and budget allocations made for the delivery of health services. It would also assist in keeping the voices of the poorest and most marginalised in the media and other population communication channels especially prior to major elections.

Community engagement is a vital component of effective healthcare delivery as communities have an active role to play in monitoring drug stocks, health worker salaries, vehicles deliveries and staff incentive schemes. This can see less misuse of funds from the system. It would also support the Paris Agreement and the principles of participation under the 1978 Alma Ata Declaration definition of Primary Health Care.

Evidence also suggests that community mobilisation can bring about cost effective and substantial reductions in mortality and improvements in the health of newborns, infants, children and mothers. The 2005 review of the WHO Integrated Management of Childhood Illness strategy states, "Delivery systems that rely solely on government health facilities must be expanded to include the full range of potential channels in a setting and include greater accountability for intervention coverage at the population level." [14]

Lessons learnt from the last ten years of civil society engagement with international health partnerships such as the Global Fund to Fight HIV/AIDs, TB and Malaria make it clear that greater civil society representation results in more effective health partnerships. Several global health partnerships such as GAVI, IHP+ and the Global Fund have taken steps to adapt their governance structures to recognise the contribution of civil society and private sector partners. The Global Fund has also attempted to build local ownership and public participation through its Country Coordinating Mechanisms (CCM) that oversee the development, implementation and monitoring of Global Fund grants. The Global Fund recommends that NGOs represent at least 40 percent of the CCM membership.[15]

DFID in African countries, such as Uganda, Tanzania and Ghana also works to support improved health services through demand led governance. For example, since 2001, DFID has supported a programme in Uganda which focuses on improving the quality of health services through demand led governance. The Uganda National Health Consumer's Organisation (UNHCO) has worked with patients, healthcare professionals and policymakers to build a health system that better responds to the needs of Uganda's people. By working at these different levels, UNHCO is helping to change attitudes to healthcare across Ugandan society, and influence the quality of healthcare (see Appendix 3). World Vision employs a similar tool called Citizen Voice in Action, outlined in Appendix 4.

A number of DFID country programmes, such as Sierra Leone, Uganda and Malawi are also supporting the advocacy efforts of non-government organisations. Such community governance mechanisms are most effective when established as part of the national and district governance systems and ensure that community monitoring teams are inclusive and representative of target groups such as mothers and children including in harder to reach populations.

14 Rosato M et al "Community participation: lessons for maternal, newborn, and child health" The Lancet, Volume 372, Issue 9642 pg. 962 - 971 13 September 2008.

15 See http://www.theglobalfund.org/documents/ccm/CCMOnePageBrief_PrtnshpAndLeadership_2008_10_en.pdf

Proposal 3: Australian Government support for the delivery of the Minimum Initial Service Package for reproductive health in crisis and post crisis African countries

World Vision encourages the Australian Government to support the delivery of the Minimum Initial Service Package (MISP) for reproductive health in emergency and protracted crises settings in Africa. This could be delivered through the establishment of a long term humanitarian grant funding mechanism for protracted crisis situations to complement the current Periodic Funding Agreement mechanism designed to address rapid onset emergencies and natural disasters.

The MISP is a set of priority activities to be implemented during the early stages of an emergency (conflict or natural disaster) and is well regarded as a best practice model to provide sexual and reproductive health in emergency and conflict settings. When implemented at the onset of an emergency, it reduces maternal and neonatal mortality and morbidity, HIV transmission. It prevents and manages the consequences of sexual violence, and provides comprehensive reproductive health services to populations affected by crises, particularly women and girls. These populations may be refugees, internally displaced persons (IDPs) or populations hosting refugees. MISP is a standard in the 2004 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response. World Vision would like to see the Australian Government take a more strategic approach and further strengthen its support for implementation of MISP in both rapid onset, protracted and post- crisis settings in Africa.

In 2007, the International Planned Parenthood Federation (IPPF) for East, Southeast Asia and the Pacific received a grant from the Humanitarian and Emergency Health Section of AusAID to manage a 3-year programme that aims to increase access to sexual and reproductive health information and services for persons surviving crisis and living in post-crisis situations in East, Southeast Asia and the Pacific.

Appendix 1: Overview of African countries that produce the most reliable midwives

Many African nations did have good systems of health care training in place but have not made enough effort to retrain or invest in staff. This corresponds with increased maternal mortality over the past ten years which can be partly attributed to a lack of human resources to deal with obstetric emergencies. Currently, many African countries include midwifery in their nurse training curriculum but do not have specific midwifery courses. This is changing, as funding for midwifery improves.

The summary below is based on World Vision staff knowledge and aims to provide an outline of African countries that produce the most reliable midwives.

- Ghana provides nurse training using the old United Kingdom (UK) model but has also introduced community midwife courses that are two years in duration in comparison to other midwife courses that are 3 - 4 years.

- Kenya uses a similar system to the old UK system, with nurse training linked to a hospital and finishing with a Registered General Nurse (RGN) qualification. This produces good midwives and they now have a separate degree offering follow-on courses.

- Liberia has 18 month competency based basic community midwife courses based on ICM approved competencies. This course has shown dramatic impact in relation to retention of knowledge and basic skills.

- Malawi has nurse training schools but they also provide direct entry midwifery training courses and have started a degree with follow-on courses.

- Uganda uses a system similar to the UK to train nurses and midwives in specific nurse training schools over three years. Both courses are linked to teaching hospitals and students receive a RGN qualification that includes midwifery. In the UK, midwives are required to be a RGN before becoming a registered midwife.

- South Africa provides a three year nurse training with extra time for midwifery - they are also recognised in the UK

- Tanzania has good nurse and midwifery schools that are aligned to the old UK system linking their training to hospitals and not through a degree. The Government of Tanzania has also taken steps to make maternal and newborn health a priority. The Reproductive and Child Health Section within the Ministry of Health has developed a new strategy - called the National Road Map – A Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania or The Plan. [16]

Up until ten years ago Sierra Leone, Zimbabwe and Zambia had excellent nurse and midwife training schools but they have not invested in them.

Appendix 2: Health Extension Program, Ethiopia

Please note that the Health Extension Program in Ethiopia has been provided as a more comprehensive example of how Australia could support health care capacity building and health

[16] The National Road Map – A Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania available at http://hdptz.esealtd.com/fileadmin/documents/Key_Sector_Documents/MNCH/One_MNCH_plan.pdf

system strengthening efforts in select African countries in partnership with national governments and other donors.

The Health Extension Program (HEP) in Ethiopia aims to improve access and equity through the provision of essential health interventions at the village and household level, with a focus on sustained preventive health actions and increased awareness. The project is implemented by the Ethiopian Government with support from DFID, the World Bank, the African Development Bank, the European Commission, Germany, Canada, Netherlands and Ireland.

The initiative deploys two salaried health extension workers (HEWs) at each village health post who are recruited from the local communities in which they will work. New recruits complete a one year training course, in a number of health prevention measures which include fieldwork, before taking up their posts. Following successful completion of the course, they are sent out in pairs into their home kebeles (rural communities) and are paid a monthly salary by the local Government. Health extension workers spend more than 70 percent of their time making home-to-home visits and communicating health messages in their communities. HEWs paying visits to new mothers, talk to them about breastfeeding, immunisation, family planning and how to prepare nutritious meals. Between 2004/05 and 2005/06 the number of bed nets distributed increased by 283%, with the number of new malaria cases falling by 20% and the number of women using contraceptives increasing from 25% to 36%. [17] HEWs are supervised by nurses and midwives. Some midwives are now undergoing further training to take on more surgical care and emergency obstetric complications.

Since 2003, the HEP has been attributed to Ethiopia fast registering impressive successes in extending affordable primary health-care services across Ethiopia. Coverage of publicly-funded health care has risen from 61% in 2003 to 87% in 2007.

A review completed in July 2008 by independent consultants with the input from WHO, UNFPA and UNICEF, showed that the HEP had achieved success in helping to prevent communicable diseases and enabling effective community participation in the planning and implementation of health care.[18] According to the HEP evaluation, 24 534 workers have been trained and deployed, representing 82 percent of the 30,000 target.

Appendix 3: The Uganda National Health Consumer's Organisation

The Uganda National Health Consumer's Organisation (UNHCO) began its programme in 1999 in the districts of Bushenyi, Luwero and Kampala. In 2001 the programme was boosted when DFID added its support, and in March 2005 UNHCO was provided with £230,000 of DFID funding to expand its activities to the districts of Wakiso in central Uganda and Iganga-Mayuge in the east of the country. A central part of UNHCO's strategy has been to work closely with local communities, informing ordinary people of their rights and encouraging them to demand the improved services that they deserve. In this way, local government, hospitals and clinics are reminded of their responsibilities to provide value for money healthcare to those whose interests they ought to represent.

17 Abebe Bekele, Mengistu Kefale, Mekonnen Tadesse *Preliminary Assessment of the Implementation of the Health Services Extension Program: The case of Southern Ethiopia* available at http://ejhd.uib.no/ejhd-v22-n3/302%20Preliminary%20assessment%20of%20the%20implementation%20of%20the%20heal.pdf

[18] Wairagala Wakabi Extension workers drive Ethiopia's primary health care *The Lancet Volume 372, Issue 9642*, pg. 880 – 880 13 September 2008.

Evidence indicates that UNHCO's approach can deliver real improvements. For example, at a poorly managed health centre in Kampala, patients were experiencing delays in receiving treatment and sometimes being forced to pay illegal charges. With help from UNHCO, a petition was organised demanding that the district address these problems. As a result of the patients mobilising to making their voices heard, illegal fees have been abolished and efforts are being taken to make medical staff more responsive to their patients' needs.

There are strong signs that the work that UNHCO has carried out within local communities has helped create more confidence in the medical system. In those areas where the programme has had a presence by training health users and health workers on policy issues, how to provide feedback, their rights and responsibilities – the numbers of people using medical services has increased significantly. For example in Bukoova health centre, there are 1500 patients, whereas before the training there were 800 patients.

UNHCO has also worked in partnership with the Government on a number of fronts, including:

- Carrying out research into patient satisfaction and rights awareness, which has informed the Ministry of Health's Health Sector Strategic Plan II.
- Contributing to the Patient's Charter – which protects patients' rights and encourages good patient/provider relations – by educating people about the standard of healthcare that they are entitled to.
- Participating in the national working group on patient safety research.
- Campaigning for more money to be put into health, which has resulted in the Ugandan Parliament making a commitment to address the financing of infant and maternal mortality measures.

Appendix 4: Community Voice in Action - Demand Led Governance Initiative: Uganda

First used as a community scorecard process by CARE Malawi, Community Based Performance Monitoring was further developed by the World Bank in the Gambia. Community Based Performance Monitoring is a demand led good governance tool where communities arrange to meet in their local health clinic or school together with staff, administrators, local representatives and politicians to examine:

- Standards set by their own governments for the provision of services in community based facilities (such as health centres and schools);
- Review the level and quality of services currently provided against these standards;
- Take the opportunity to rate the quality and performance of the services currently provided; and
- Set reforms and action plans in a public forum, where facility staff, as well as government and political representatives, are asked to take some responsibility for implementing the action plan.

In 2004, World Vision Australia commenced a pilot of an adapted model of Community Based Performance Monitoring, Citizen Voice in Action (CVA) in Uganda focusing on primary schools and health centres within World Vision Uganda programming areas. Uganda provided a favourable political and social context, with the government taking specific actions to reduce poverty through initiatives such as the World Bank-initiated Poverty Reduction Strategy Paper (PRSP). Through the Ministry of Finance, the Ugandan Government also recognises that grassroot organisations can play a vital role in collecting data that will assist in the overall campaign to reduce poverty.

At Nabyewanga Health Centre in central Uganda, inadequate buildings and water facilities were identified through the CVA process. Community members armed with new-found confidence and knowledge, approached their member of parliament who provided one million Ugandan shillings (A$500) as a contribution to improving the quality of existing services.

At the Buseese Primary School, parents learnt that whilst their school's teacher/student ratio was one teacher to every 186 students, the government's standard was one teacher per 60 students. The poor performance of the students could be addressed fairly simply by securing the two additional teachers the school was entitled to. Unsurprisingly, the community agreed to put a plan in place to secure more teachers. Within months of the community process, and as a direct result of CVA, the school had two new teachers on staff.

Local politicians have also seen the benefits in promoting civic rights through CVA. In Nkosi, 80 kilometres south of the Ugandan capital of Kampala, the political representative of the local sub county, Mr Ssendaula Fulgensio, commented that:

"The key thing that CVA has done is to mobilise the community. They know their rights. The community now knows what they are supposed to get from the sub county. They are in a position to track their services. The community is able to say no to substandard service. Politicians normally promise air but because CVA is in place the community has come out with a vision and know what they want and are asking for politicians to do what they promised."

For CVA to work, governments must have the capacity to be receptive to the voices of community members to be constructively heard and answered. When mandated political space is present, CVA offers the community an opportunity to consider their government's performance against its own standards. Furthermore, the opportunity provided by community members to share and voice their perceptions about the level and quality of services provided to them, in the presence of government and political representatives, can be empowering and open up new channels for dialogue.