Partnership Works to Prevent Maternal Deaths in Zambia

Context

Despite the enormous reductions in child mortality across the world, the African continent remains a perilous place for mothers and newborns. The region accounts for almost half of all maternal deaths worldwide (WHO 2016). Besides the terrible loss of life, maternal deaths take a toll on surviving family members, hampering their health, education, and economic opportunities. In Zambia in 2010, there were 591 maternal deaths per 100,000 live births. A woman’s lifetime risk of maternal death is 3 times higher in Sub-Saharan Africa than it is in South Asia and almost 30 times higher than that in developing countries (WHO and others 2014, 68). Despite modest improvements in health since the 1990s, by 2010 the maternal rate of mortality had not improved in Zambia. Knowledge of infant care was low in the country, and long distances to health centers delayed life-saving care. Furthermore, the high prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in the country complicated the effect of health programs.

Development Challenge

The challenge for Zambia was to rapidly reduce maternal and newborn mortality rates.

Intervention

In 2012, as part of its Global Health Initiative, the U.S. government launched a public-private partnership dedicated to drastically reducing maternal and newborn mortality in Sub-Saharan Africa. Called Saving Mothers, Giving Life (SMGL), the partnership focused on the three main challenges linked to maternal and newborn deaths: (a) delays in seeking care, (b) delays in reaching care, and (c) delays in receiving care (WHO and others 2014). The governments of Zambia and Uganda were the two local partners of the program at the launch; the government of Norway, Merck for Mothers, Every Mother Counts, Project C.U.R.E., and the American College of Obstetricians and Gynecologists were international partners and donors. Working closely with existing health networks—both public and private—and strongly aligned with the existing Zambia Ministry of Health plans, SMGL deployed an approach known as “systems strengthening” at the district level to reduce delays and bottlenecks in eight key regions in Zambia. Program costs in the first year were covered through donor funds (including an US$80 million commitment from the government of Norway), but outlays from the governments of Zambia and Uganda were substantial and have become the main source of funding for the program today (SMGL 2014a).

In just one year, the program achieved robust health outcomes in the targeted districts, including: (a) a 55 percent reduction in maternal mortality ratio, (b) a 38 percent increase in births at health facilities, and (c) a 44 percent decrease of stillbirth and newborn deaths in the eight target regions of Zambia (SMGL 2014a). Evaluations of the partnership point to improved coordination, improved delivery of HIV care, and better quality of care in health facilities trained in the systems-strengthening approach as the key drivers of change (Serbanescu and others 2017). Today, the program operates in 10 additional districts in Zambia and has expanded operations to Nigeria.
Delivery Challenges

This delivery note analyzes key implementation challenges and examines how they were overcome.

**Weak state health capacity**
- The greatest challenge of the SMGL partnership was a lack of staff in hospitals and medical centers in its target districts in Zambia. Most health centers (mid-level facilities for routine obstetric care) and health posts (rural outpatient facilities) had a shortage of trained personnel capable of delivering care to expectant mothers or were below the staffing requirements recommended by the Ministry of Health (CDC 2014). Even in hospitals with an adequate number of doctors and nurses on site, maternal and newborn health indicators were low because of a lack of training on emergency obstetric care procedures.
- Significant capacity gaps in infrastructure were also present, particularly in transportation and communications. At the start of the SMGL program, only 45 percent of all health centers and posts in the target sites had any communication systems, which are crucial for medical referrals in case of emergencies (CDC 2014). Moreover, both patients and health workers had insufficient transportation options. On average, most women are 3 miles from the nearest facility capable of providing childbirth care and are nearly 15 miles from health centers that can deal with birth complications (Gabrysch and others 2011).
- Finally, health providers lacked adequate data and collection techniques to monitor the access and quality of service and to diagnose potentially life-threatening complications.

**Absence of advocacy and awareness campaigns**
- A second challenge for maternal health in Zambia was the lack of awareness of best practices and services for antenatal and postnatal care. Besides the supply barriers to obtaining health services (lack of qualified staff, distance from health centers), expectant mothers lacked information and autonomy to decide on the best course of action during their pregnancies. Negative experiences with health centers that lacked medicine and qualified personnel further discouraged expectant mothers from seeking medical attention.
- Moreover, trust and reliance on traditional birth attendants (who aid mothers at home) made women less likely to travel and use health facilities, even in cases where they were near such facilities (Sialubanje and others 2014).

Addressing Delivery Challenges

The following steps were taken to mitigate the delivery challenges related to weak state capacity to deliver health services:

- To deal with the capacity gaps around maternal health, SMGL has trained a large number of midwives. Such training has been a cost-effective and high-impact intervention to provide support for birth and effectively deal with potential complications. Through workshops and mentorship programs, the partnership also strengthened midwives’ and nurses’ skills in emergency obstetric and neonatal care. The number of midwives trained in these techniques more than doubled—from 68 to 151—after the SMGL interventions (CDC 2014).
- To improve access to health centers and clinics, SMGL also used Short Message Service, or SMS, to transfer funds and vouchers to cover the cost of transportation to health centers during labor or in the case of emergencies.
- The partnership purchased vehicles and motorcycle ambulances to address the lack of emergency transportation (SMGL 2014b).
- Working with Zambia’s Ministry of Health and the Centers for Disease Control and Prevention, a U.S. federal agency, SMGL has created a baseline survey of health outcomes around maternal health.
- To collect up-to-date information on maternal deaths and health, SMGL trained village health teams and community workers. These individuals tracked women who received medical care, monitoring the quality of service from the time the women visited health centers until 42 days postpartum.

The following steps were taken to mitigate the delivery challenges related to the absence of advocacy and awareness campaigns:

- To encourage and motivate women to use medical services during pregnancy and childbirth, the SMGL partnership created a series of community outreach campaigns. These programs focused on providing greater information on birth planning, pre- and postpartum home care, and the value of visiting maternal and newborn health facilities.
The campaigns were delivered by trained groups of women from the local community and specifically sought the involvement of village leaders and men to encourage participation.

- In total, SMGL has trained approximately 6,000 community workers, local leaders, and advocates to promote key behavior-change messages and to generate demand for maternal health services. Many of these activities were shared through musical performances and drama skits to incite community participation and understanding. These activities were supplemented by mass media campaigns through radio broadcasts (Kruk and others 2013).

- Finally, SMGL provided a small package containing essential newborn and birth supplies such as gauze, antibacterial soap, and blankets. These packages, dubbed “Mama Kits,” were crucial to providing an incentive for facility-based births and to helping households save substantial sums in the purchase of basic goods (Kruk and others 2013). More than 4,000 of these kits were distributed in Zambia alone.

References


