Closing the loop: translating evidence into enhanced strategies to reduce maternal mortality

Washington DC

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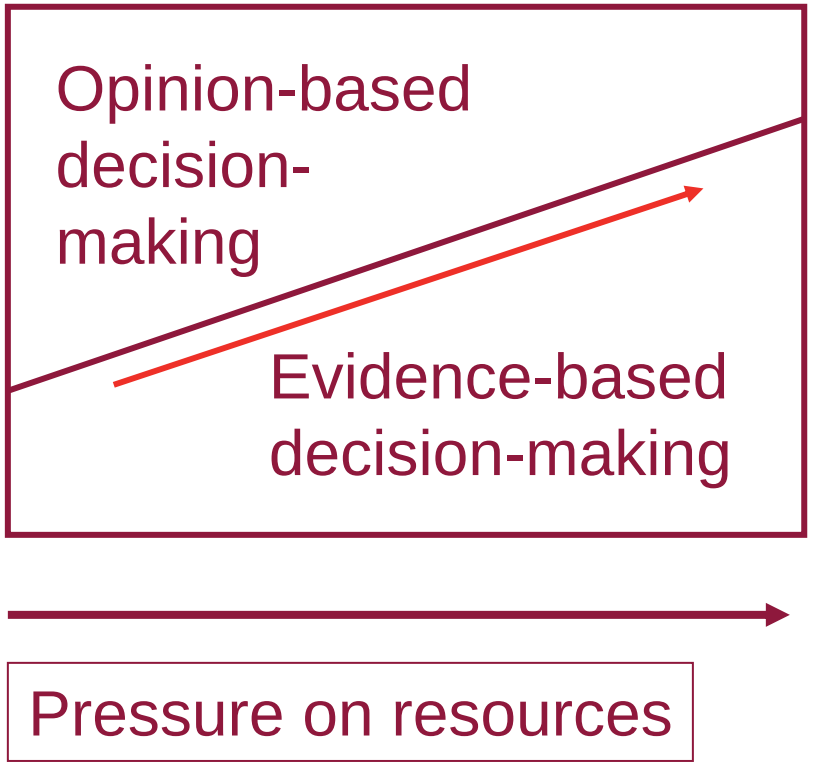
Professor Wendy J Graham

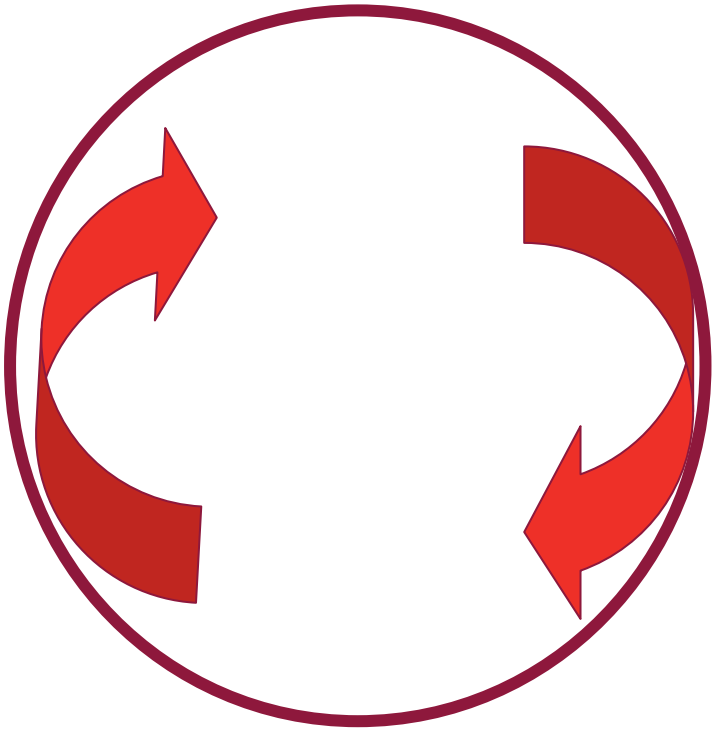
1495 UNIVERSITY OF ABERDEEN


Opinion-based decision-making
Evidence-based decision-making
Pressure on resources

Immpact “closing the loop”

Assessing decision-makers’ priorities for evidence

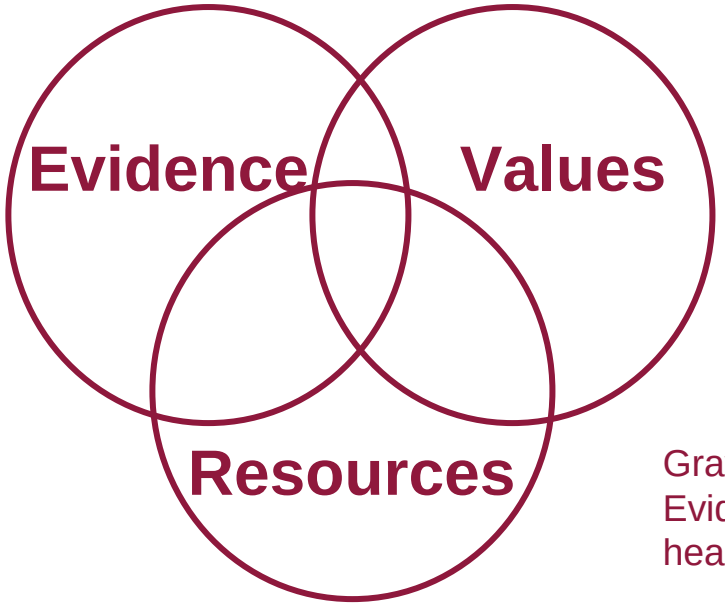
Using evidence to inform the design, implementation & evaluation of enhanced strategies



Gathering & synthesizing evidence

Communicating & translating evidence for decision-making

Political challenges to translation



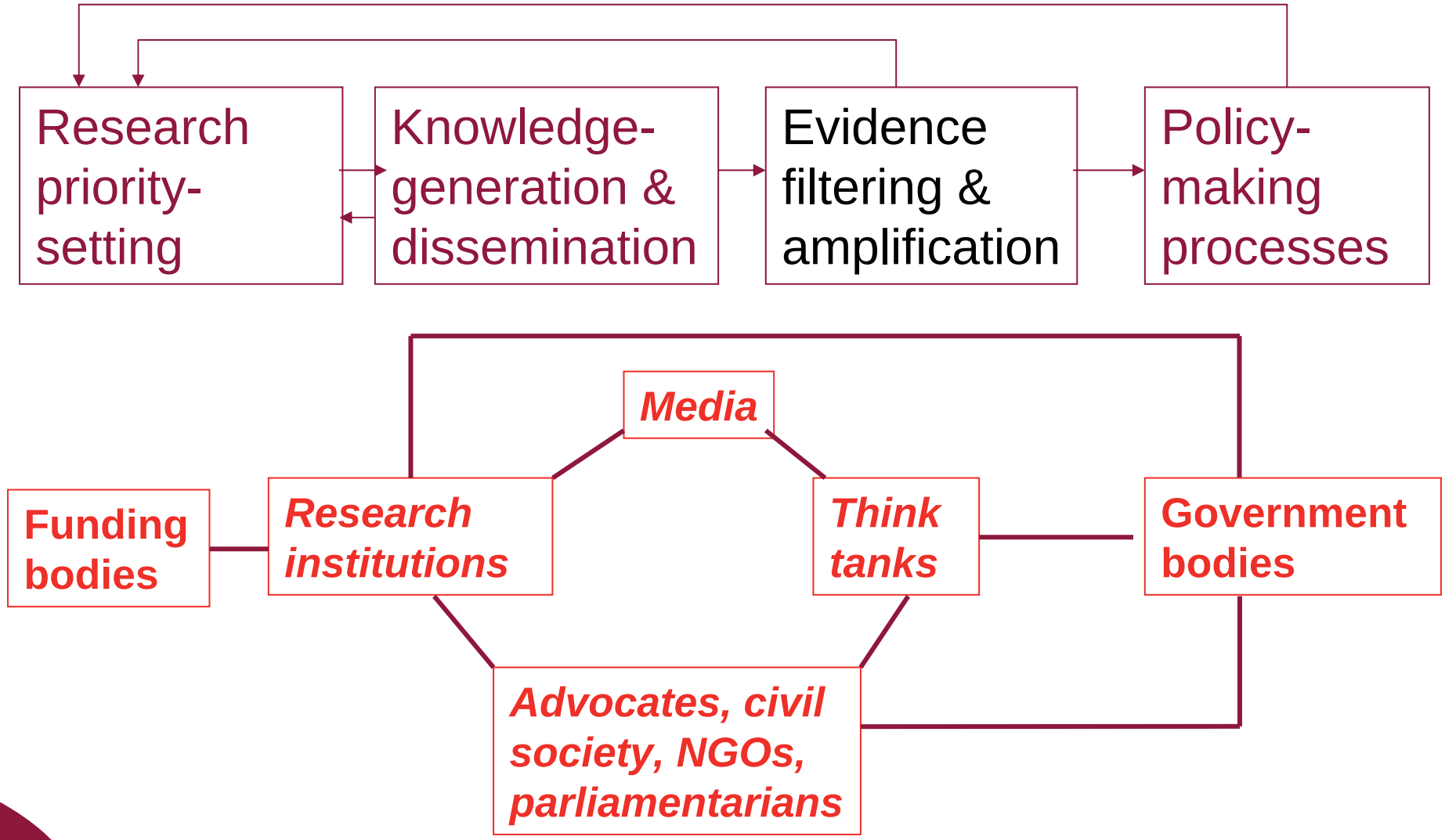
Gray, J.A.M 1997
Evidence-based
health care.

"There is nothing a politician likes so little as to be well informed; it makes decision-making so complex and difficult."

J M Keynes (1883-1946)

Researchers are from Venus.
Policy makers are from Mars.

Demand for evidence is now more diverse



Adapted from: Alliance for Health Policy and Systems Research. 2007.

Four “translated” messages from Immpact

1. The burden of maternal mortality is borne disproportionately by the poorest or most disadvantaged women.

2. Financial barriers to emergency care & skilled delivery are major reasons for this burden & inequity.

3. Many current strategies for universal access aim to reach the poor but tend to reach the non-poor.

4. Phased & targeted approaches to reducing financial barriers & assuring quality of care could catalyse progress towards MDG5 & MDG4.

Financial strategies to reach the poor

1. Ensure financial access to delivery services

- Fully fund costs of complicated deliveries
- Stimulate demand for skilled delivery
- Encourage households/communities to plan for costs
- Make universally available or geographic targeting

2. Motivate midwives to deliver services to the poor

- Ensure adequate income for all or target payments

3. Political and financial commitment underpins 1 & 2

- Ensure sufficiency of resources
- Effectively manage & release resources

Timeliness of evidence in Indonesia

- Presidential concern for MDG5
- On-going Health Sector Review
- Revision of National Health System document
- Election in 2009
- Strengthening of district-level decision-making

Wider call for new strategic focus


THE LANCET

Maternal Survival · September, 2006 www.thelancet.com

"The next 12–18 months will be critical for safe motherhood advocacy, offering an unprecedented chance to redress errors of the past and take advantage of new opportunities."

See Comment page 2

Maternal Survival

All women should be able to deliver in primary level health facilities *(health centres)*, with midwives working in teams:

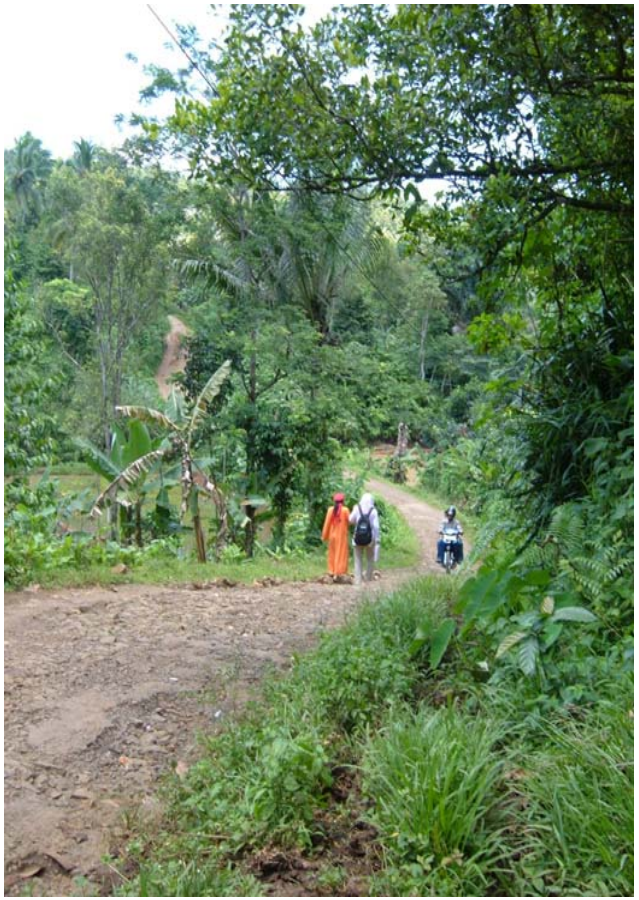
- **Most effective** (impact on mortality) because skilled attendants can provide proven single interventions & rapid referral
- **More efficient** (achieving high coverage) than skilled attendants in the home or hospital

Tailored key messages from Immpact Indonesia

1. The burden of maternal mortality is borne disproportionately by the poorest but remains an issue for all groups.

2.Financial barriers to emergency care & skilled delivery are major reasons for this burden & lead to impoverishment.

3. Universal access to quality delivery care should be driven by explicit goals for type of place as well as type of provider.

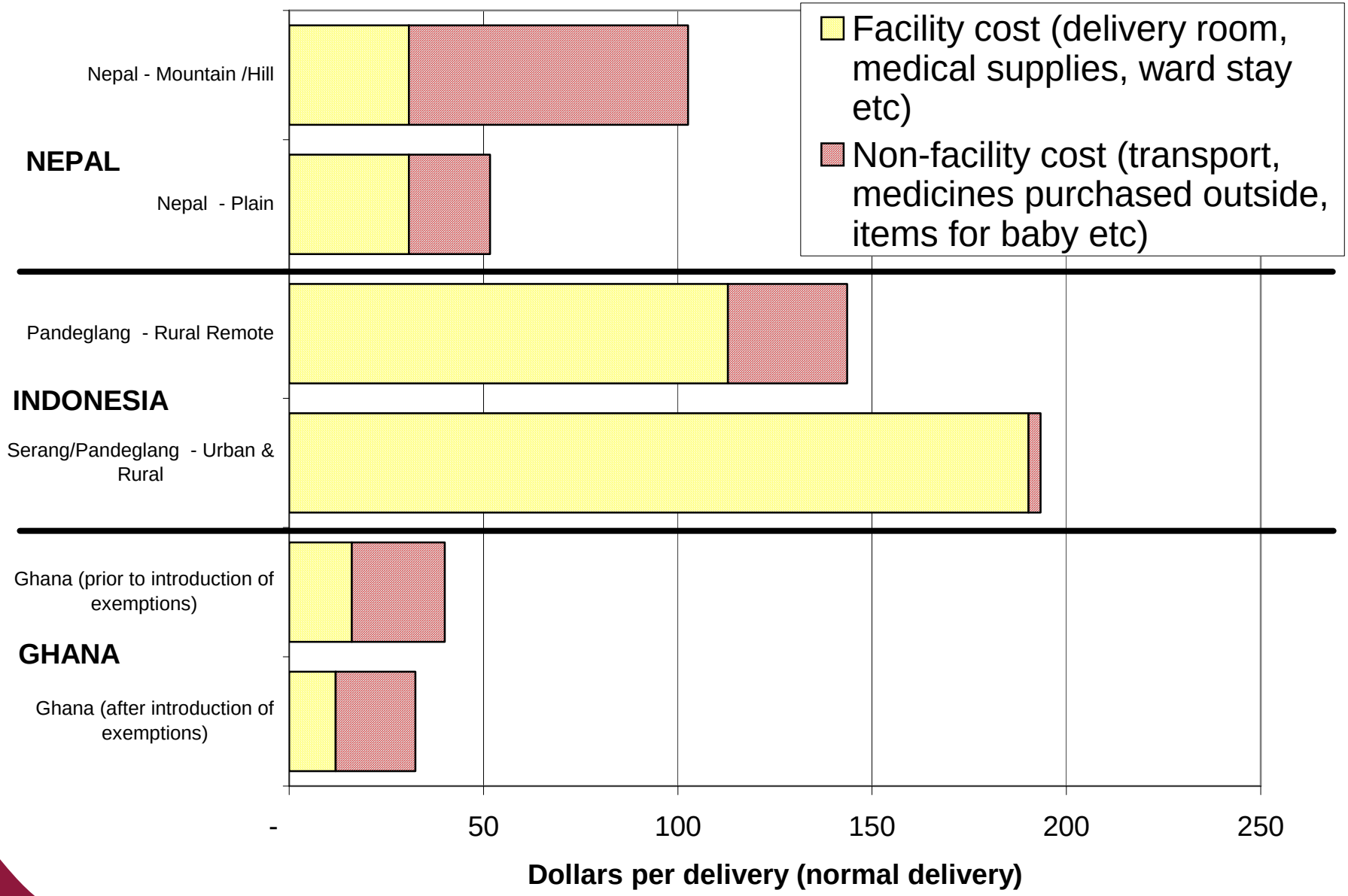


4. Phased & targeted approaches to reducing financial barriers & assuring quality of care could catalyse progress towards MDG5 & MDG4.

Four steps in developing financing strategies for maternal health

1. Focus on most important barrier to households
2. Address supply environment
3. Ensure financial coverage of catastrophic maternal care
4. Develop action plan

1. Focus on most important barrier to households



2. Address supply environment

- As contexts vary, so too do optimum financing strategies
- Little point in strengthening demand for services if supply is inadequate
- Suggests context determined both a) by extent of demand side costs and b) supply environment

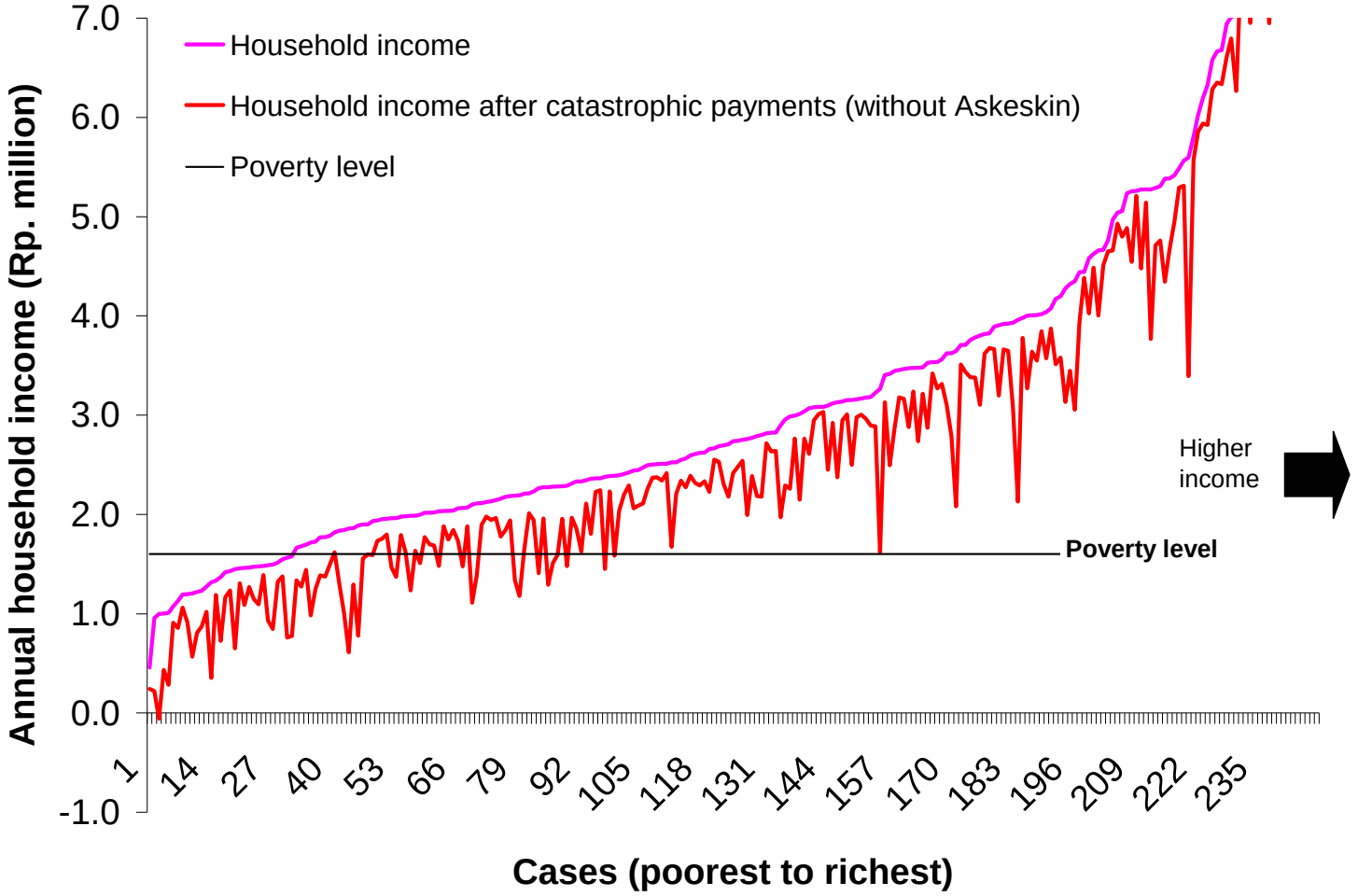
		Demand		
		High demand-side costs (poor roads)	Low demand-side costs (good roads)	
Supply	Adequate infrastructure	Turkmenistan, Somalia, Zambia, Gabon, Cambodia, Sudan, Myanmar, Botswana, Papua New Guinea, Afghanistan, Iraq, Kenya **II.**	Brazil, Azerbaijan, Philippines, Burundi, Malawi, India, Mexico, Cameroon, Tajikistan, Nigeria, Swaziland, Lesotho, South Africa, Haiti, Zimbabwe **I**	Sufficient midwives and CEOC beds
	Weak infrastructure	Nepal ; Liberia, Senegal, Central African Republic, Guinea-Bissau, Burkina Faso, Mauritania, Mozambique, Niger, Madagascar, Mali, Chad, Benin, Ethiopia **IV.**	Bangladesh ; Pakistan, Guinea, China, Ghana, Uganda, Togo, Rwanda, Rwanda, Sierra Leone **III.**	Sufficient Midwives and sufficient beds OR insufficient CEOC beds and sufficient midwives Insufficient midwives and insufficient CEOC beds

Indonesian contexts

		Demand		
		High demand-side costs (poor roads)	Low demand-side costs (good roads)	
Supply	Adequate infrastructure	**e.g. Central Java** **II.**	**e.g. Serang; Jakarta** **I.**	Sufficient midwives and CEOC beds
	Weak infrastructure	**e.g. Pandeglang** **IV**	**e.g. ??** **III**	Sufficient Midwives and sufficient beds OR insufficient CEOC beds and sufficient midwives Insufficient midwives and insufficient CEOC beds

Indonesia

3. Ensure financial coverage of catastrophic maternal care



If all that 'needed' CEmOC accessed, **up to 33% could be pushed into poverty without assistance**

4. Develop action plan

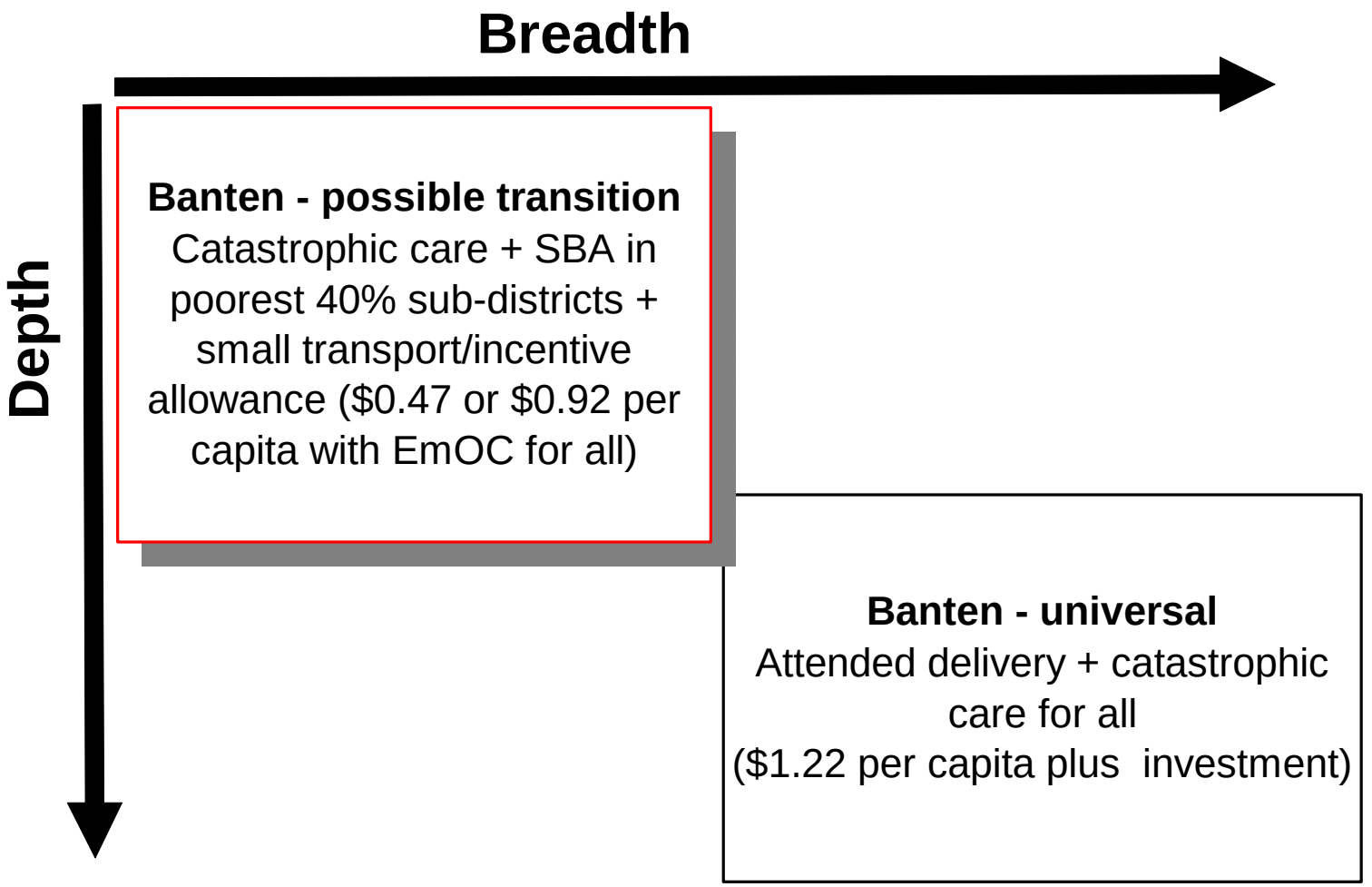
Towards universal access to maternity care:

A. Plan depends on context (demand-side and supply)

B. Financing mechanisms

C. Affordability - requires strategic prioritisation

An example of a phased strategy

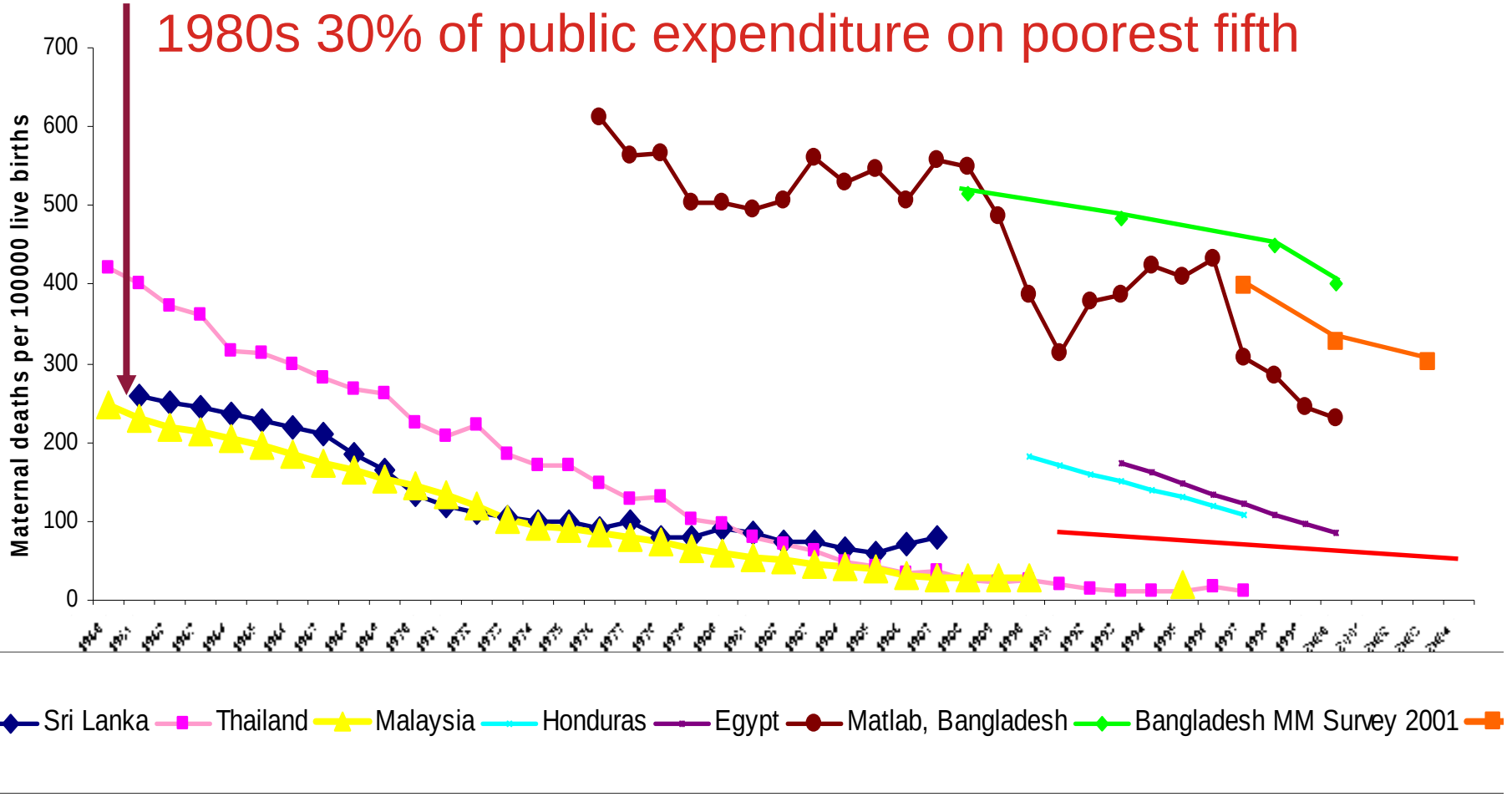


Public health spending **$8 pc (Indonesia)**

Maternal Health **$0.3 pc (Banten)**

Success: countries with falling maternal mortality

Malaysia: 1960s policy changes to address poverty; 1980s 30% of public expenditure on poorest fifth



We can achieve MDG 5 with a clearer focus on the poor

Thank you.

www.immpact-international.org

An emerging strategy towards Universal access in Indonesia

Ultimate goal: universal access to delivery care at health centres and universal access to CEmOC at hospitals

Ingredients for phasing:

- Funding for (selected – populous, poor) districts to provide 'free' CEmOC
- Develop quality of care standards for ultimate hospital certification
- Funding for the poor for normal delivery eventually only for services at puskesmas (through Askeskin?)
- Strengthen puskesmas in poor/remote sub-districts
- Strengthen puskesmas-based emergency transport
- Revise incentives for bidan to deliver (poor) women (Askeskin payments) and encourage TBAs to refer to bidans
- Transport subsidy/incentive to deliver at health centres