

Improving maternal health when resources are limited

Safe motherhood in rural Rwanda

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Despite significant improvements in its maternal health indicators, sub-Saharan Africa remains one of the most dangerous regions in the world in which to give birth. Ensuring safe motherhood for rural African women requires a package of goods and services, provided by a number of different actors. But every part of this package can face delivery challenges.² Typical bottlenecks at the local point of delivery include poor quality health care and professional standards, low staff morale and motivation, delays in transferring women to higher-level health facilities and choices about health-care that reflect suspicion of modern health services.



An ante-natal session, Rugege health centre ©Victoria Chambers

Over the past decade, Rwanda has managed to overcome many of the critical bottlenecks to make impressive progress on maternal health. It has done so despite the fact that health spending per capita in the country remains below the sub-Saharan African average.³

Africa Power and Politics (APPP) carried out eleven months of fieldwork during 2009-2011 in the rural Rwandan districts of Nyamagabe and Musanze. This indicates that substantial gains can be made, even in the absence of adequate material resources.⁴

Outcomes in Rwanda

According to the latest data at the national level, including the Preliminary Rwanda Demographic Health Survey 2010 (Table 1):

- Maternal mortality rates have fallen steeply, from 1,071 per 100,000 live births in 2000 to a recorded 383 per 100,000 in 2010
- 69% of women now give birth at health centres
- 98% of expectant mothers attend at least one ante-natal consultation (ANC) during their pregnancy
- Modern contraceptive use quadrupled between 2005 and 2010.

Findings from the APPP's village studies in Nyamagabe and Musanze districts are consistent with the national data and point to factors that may explain the progress being made:

- Many interviewees struggle to recall recent cases of women dying in childbirth
- Villagers have access to well-equipped health centres staffed by professionals who offer family planning as well as childbirth facilities and ante-natal care
- Many households are choosing to limit family size and space births
- Accidental home births are now usually avoided, thanks in part to 'waiting wards' at health centres
- Enrolment rates in the national community health insurance scheme (*mutuelle*) are high
- Many villagers seem to understand the concept of risk-pooling that is the basis of the *mutuelle*
- Health centres are quick to transfer women with childbirth complications to district hospitals, for which there are functioning ambulances
- Partners often accompany women to their first ANC sessions, where both undergo HIV testing. HIV-positive expectant mothers are integrated into transmission prevention programmes.

Table 1: Rwanda's maternal health indicators: 2000-2010

		2000 ¹	2005 ²	2010 ³
Maternal mortality rate (MMR) per 100,000 live births	Total	1,071	750	383 ⁴
Total fertility rate (TFR)	Total	5.8	6.1	4.6
	<i>Rural</i>	5.9	6.3	4.8
Modern contraceptive prevalence (%)	Total	4.3	10.3	45.1
	<i>Rural</i>	2.6	8.6	44.9
Births at health facility (%)	Total	26.5	28.2	68.9
	<i>Rural</i>	19.8	23.8	67.1
Women receiving at least one ANC (%)	Total	92.5	94.4	98.0
	<i>Rural</i>	-	94.4	98.0
Women receiving at least four ANC (%)	Total	10.4	13.0	35.4
	<i>Rural</i>	-	9.5	34.7

Sources: ¹Rwanda Demographic Health Survey (RDHS) 2000 ²RDHS 2005 ³Preliminary RDHS 2010 ⁴Rwanda Health Management Information System

Overcoming bottlenecks

Institutional features falling into three main areas help to explain how critical bottlenecks have been overcome to produce these improvements.

Policy coherence

First, the local maternal health delivery arena functions within a highly coherent policy environment. The Rwandan government's commitment to improving maternal health has been reflected in consistent national and local-level objectives, and mutually reinforcing policy reforms and implementation strategies. The regime's single-mindedness in pushing through policy reforms has created a favourable context for action to improve maternal health outcomes.

Of course, the post-genocide era offered a unique window of opportunity for joined-up policy-making. However, the new policies have not been painted on an entirely blank canvas. A serious attempt has been made to build a collective vision of a common future by tapping into familiar or revived Rwandan cultural values. Formerly significant Rwandan institutions have been harnessed in innovative ways to provide practical performance inducements (*imihigo*) and inputs to participatory planning processes (*ubudehe*). These arrangements have helped to create a local environment that is generally conducive to change.

“ **consistent incentives have played a key role.** ”

In the health field, strategies such as nationwide health insurance and the use of voluntary community health workers (CHWs) have enabled critical financial and human resource bottlenecks to be at least partially overcome:

- For an annual *mutuelle* contribution within most households' financial reach, rural pregnant women now have access to life-saving maternal health services. Emergency transfers by ambulance from health centres to district hospitals, and surgical interventions that would once have been unaffordable, are now routine.
- In principle, there is a maternal health CHW in every Rwandan village. These volunteers play a critical role in supplementing the stretched capacity of public sector health workers and local authority staff. CHWs identify, follow up on, and educate, pregnant women.

A significant factor supporting policy coherence is the government's successful management and coordination of development partner (DP) activity at national and local levels. This has ensured that donor-driven duplication has been largely avoided in maternal health. At the same time, external financial support has made it possible to plug real resource gaps – for example, donor funds are used to pay the health insurance of especially vulnerable villagers.

Performance discipline

The coherence of the policy environment has helped to establish clear lines of authority between the different agencies responsible for the implementation of government policy on maternal health. This has enabled the imposition of strong performance-focused upward accountability measures.

APPP's fieldwork has documented the existence of regular and effective supervision and monitoring arrangements between the different levels of local maternal health service provision. These appear to play a critical role in ensuring that professional standards are respected and that policy is implemented:

- Health centres are regularly evaluated by district hospital staff for performance-based financing (PBF)
- Maternal health CHWs are supervised by coordinators who visit them in their homes and provide them with continuous training
- Monthly reporting on progress towards agreed performance goals, such as increased family planning, at every local authority level keeps local government entities in check.

At each level, there are real consequences for actors who fail to achieve sufficient performance levels. The Rwandan health system has been decentralised. However, the decentralisation of service delivery has reinforced, rather than weakened, the link between the state and local government. Local actors in the maternal health service delivery arena remain very much accountable to the national state apparatus. Improvements in service delivery have, therefore, been substantially driven by top-down performance pressures.

The upward accountability mechanisms have been accompanied by consistent incentives – moral and material rewards and sanctions – that ensure that actors are motivated and work towards the same goals (Table 2). These general incentives are sometimes supplemented by particular measures that directly promote the government’s maternal health policy. For example, in order to maximise the financial bonuses they receive from performance-based financing (PBF) some health centres pay commissions to CHWs to encourage them to escort expectant mothers to their facilities, thereby increasing the number of births that take place in health centres.

Table 2: Examples of incentives

	Rewards	Sanctions
Users	Free gifts for ANC attendance	Fines are imposed for home births
CHWs	Cash incentives via income-generating cooperatives	CHWs can be removed from their post
Health service providers	Monetary incentives for good PBF evaluations	Immediate health centre audit in the case of a maternal death
Local authority staff	Local authority rankings (<i>imihigo</i>) confer status on good performers	Officials can lose their jobs for poor performance

Source: Observational fieldwork in Nyamagabe and Musanze districts, 2009-2011

Other government policies minimise incentives that could create bottlenecks. For example, forbidding public sector health workers to run private healthcare facilities removes an incentive that in other countries encourages public sector absenteeism.

Facilitating local engagement

A third set of institutional features seems to have contributed to the gains in maternal health. This concerns government facilitation of coordination and mutual engagement by local actors. The way the decentralisation policy has been carried out in Rwanda appears to have been reasonably effective in creating arenas where different actors come together to coordinate their actions.

“ **bottom-up engagement did not arise spontaneously.** ”

For example, joint health advisory and oversight committees – nearly defunct in some of the African countries where they have been introduced – do seem to work in Rwanda to ensure collaboration among local authorities and health service providers at the district and sub-district (‘sector’) levels. These health committees permit the various actors to co-monitor maternal health indicators, identify problem areas and find cooperative ways to address them.

Although service users are represented on these bodies, they cannot be said to arise from a bottom-up ‘demand’ for better services. They are driven by the state.

At another level, state-promoted local participation has also been important in achieving critical changes in behaviour on the part of service users – pregnant women and their partners.

Persuading local rural populations to stop giving birth at home and to start using modern family planning methods to limit or space childbirths has required significant shifts in behaviour. Women have typically given birth at home and family planning has been associated with immorality. Similarly, encouraging people to pay for health insurance when they are not ill is a significant challenge in communities with weakly monetised economies.

Integrated public education efforts facilitated by the state are making a significant contribution to changing mindsets. Village meetings, community works (*umuganda*) occasions, and health centre information, education and communication sessions (IECs) are the arenas in which these efforts take place. They also serve in more practical ways as places for identifying and dealing with critical bottlenecks which could adversely affect the application of the maternal health policy.

For example, recognising the financial burden placed on poor families by obligatory health insurance, the state has used local meetings to encourage savings clubs that enable villagers to pay their health insurance in instalments. Meanwhile, the poverty reduction scheme *ubudehe* provides a participatory means of classifying poor village households so that the most vulnerable can be identified for assistance. Through these mechanisms, the economic factors that would otherwise prevent behaviour change are able to be addressed.

In summary, local coordination and citizen participation have been important features of the Rwandan change model. Crucially, however, this has required top-down state policies to motivate and facilitate collective action in particular arenas. Bottom-up demand and engagement were not expected to arise spontaneously.

Lessons from Rwanda

Rwanda has followed a distinctive historical path. Reconstruction after war and genocide has taken place within a political culture that began to be shaped in the era when the country was a unified kingdom. These contextual features are not easily replicated elsewhere. Also, the government's current attitudes to democratic political competition and its policy-implementation style are controversial. They reflect a view of the trade-off between political liberties and development results that not everyone accepts. Nonetheless, there are some general lessons to be drawn from Rwanda's experience.

It's not just about material resources ...

Typically, development actors highlight resource shortages and training gaps as major factors in the under-provision of reproductive and maternal health services in rural sub-Saharan Africa. However, the Rwanda case suggests that focusing on the inadequacies of the material resources devoted to the problem can be misleading.

In materially constrained environments, it is vital to recognise the institutional resources that can be mobilised to help overcome local service-delivery bottlenecks. Rwandan experience suggests that in many contexts more could be done with existing resources, and that in the absence of such efforts, additional resources might contribute little.

... and it's not a one-way street

In Rwanda, improvements in maternal health have been the result of a double movement. Rules have been enforced and performance pressures have been exerted on service delivery actors from the top down. On the other hand, a key feature has been the creation of local spaces where coordinated ways of working can be developed and key bottlenecks can be addressed. Citizen participation has also been critical in stimulating processes of behavioural change. While upward accountability has been necessary, so has the generation and harnessing of popular support.

Lessons from Rwanda have wider relevance. Policy reform in much of Africa has struggled to achieve a satisfactory marriage of the so-called 'supply' and 'demand' sides of improving public services. The Rwanda experience not only underlines the critical role of non-material resources in the achievement of development breakthroughs in poor countries; it also confirms that policy drive from the top down is a critical condition for progress at the grass roots.

References

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