

Angola health survey: Opportunities to reduce maternal and newborn mortality



This brief is based on data collected in the Cazenga, Klimba Kiayi and Ingombota municipalities in the Luanda province, and in the Uíge, Quitexe and Puri municipalities in the Uíge province in collaboration between CMI and CEIC in 2010.

40 health facilities (6 hospitals, 19 health centers and 15 health posts) and 953 households, were at least on child was born the last five years, were surveyed. About 70% of the households were located in urban areas. In the country as a whole, 60% of the population is urban.

In Angola, every tenth child dies before the age of one. 40% of these deaths happen within 28 days of birth. Angola has among the highest maternal and child mortality rates in the world. To reduce the number of deaths is one of the top priorities in the 2010 National Health Policy. This brief outlines findings from a statistical survey of essential maternal and child health service availability and utilization in the provinces of Luanda and Uíge. The priority for the Angolan government should be to make sure that all women are attended by a skilled health worker during delivery, also in rural areas, and increase the availability of emergency obstetric care.

The day of birth is the most dangerous day in the life of a woman and her child. Universal coverage of skilled attendants and access to emergency obstetric care during delivery are the most crucial interventions to save mothers and their newborn babies. In addition, women need health checks to detect and treat infections and prevent diseases during pregnancy. After birth, mother and child should be checked by a health worker to detect and refer illness, and to promote breastfeeding, family planning and hygienic practices in the household.

Most maternal and newborn deaths could be avoided through these essential health services.

WHO RECOMMENDATIONS

The World Health Organization recommends that the following should be available to, and used by, all women.

- During pregnancy: attend at least four health checks
- During child birth: be accompanied by a

skilled attendant (doctor, nurse or midwife) and have access to emergency obstetric care in case of complications

- After pregnancy (facility based births): follow-up visits to both mother and child as soon as possible after return to home
- After pregnancy (home based births): one follow-up visit within 24 hours, and on the third day, after birth

AVAILABILITY OF SERVICES

There is substantial urban-rural variation in the range of services offered at the health facilities. In urban areas, 90% of facilities offer health checks during pregnancy compared to 25% in rural locations. Delivery and follow-up services are provided by about half the urban facilities, but only one in four of the rural facilities.

CONTROLS DURING PREGNANCY

It seems Angolan women perceive health checks during pregnancy to be important. Pregnancy control attendance is high. In the urban households, more than nine in ten women had one, and eight in ten had at least four, health checks during their last pregnancy. Also in rural areas, many women attended pregnancy care (eight in ten had one, six in ten had four or more, checks). This is despite a low share of rural facilities providing pregnancy controls. Thus, many of the women who live nearby a facility that

does not offer these services seek them at other facilities.

Yet the content of the health checks must be improved. Tetanus and malaria contribute to many newborn deaths. 91% of women in urban, and 78% in rural areas received a tetanus injection during their last pregnancy. Only half of the pregnant women in the rural areas were offered anti malaria drugs. One of three facilities did not even have anti-malaria drugs in stock. The prevalence of HIV in Angola is low compared to other sub Saharan countries. Yet, testing and prevention of transmission is crucial in keeping it that way. Only 33% of the rural women were tested for HIV. Only 7 (all urban) of the 40 facilities provide prevention of transmission from mother to child services (PMTCT).

SKILLED BIRTH ATTENDANCE AND EMERGENCY CARE

The coverage of skilled attendants is far from universal in the surveyed households, and the urban-rural inequalities are stark. While 82% of urban women had skilled birth attendants, only 32% of women were assisted by a doctor, nurse or midwife during delivery in rural areas (fig 1).

Women in rural areas only have limited access to professional assistance during delivery. The women who did not give birth in a health facility were asked to specify the reasons why (fig 2). 30% in urban and

Figure 1: Share of women attended by a doctor, nurse or midwife during last delivery.

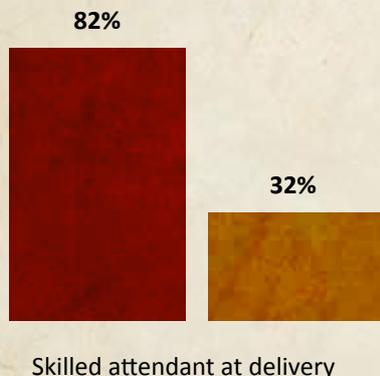
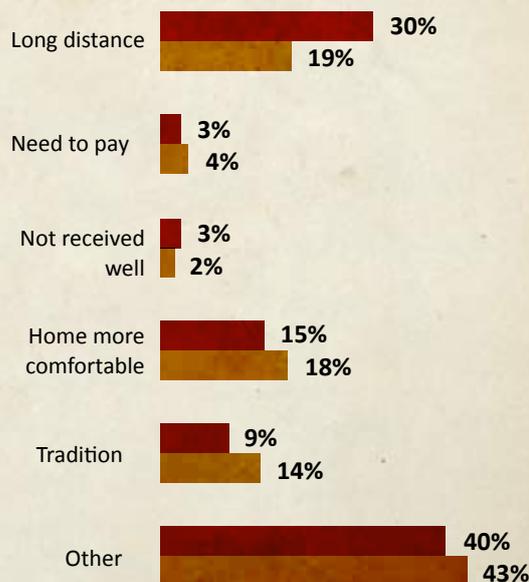


Figure 2: Reasons not to give birth in a health facility



Urban Rural

18.5% in rural households answered “Long distance”. Accessibility is important to both urban and rural households, but is more decisive for use in urban areas.

“Home more comfortable” and “Tradition” are other frequently mentioned reasons. Thus, availability is not the sole obstacle to use of skilled attendants. Perceived comfort and tradition keep women at home. Many women do not know about the about the benefits of skilled attendants.

Very few facilities provide sufficient services and drugs to assist women that experience complications during childbirth. Caesarian section is needed by between 5% and 15% of all pregnant women. This service should be available at all hospitals. Yet only one single (of six) hospital had the equipment to perform the procedure satisfactorily.

Essential drugs are in shortage at all except one of the eighteen facilities that provide delivery services. Bleedings after delivery is the most common cause of maternal deaths. It is therefore particularly worrying that only 7 (all in urban areas) of the facilities with delivery services had drugs that prevent bleeding in stock.

CONTROLS AFTER BIRTH

Many women and children did not receive a follow-up visit within one week after birth. Geographical inequalities are substantial, but smaller than for skilled attendance. About seven in ten mothers and children received a follow-up visit within one week in urban areas. In rural areas this share was four in ten.

Breastfeeding significantly improves a newborn’s chances of survival because the milk contains important nutrition and antibodies. Still many women, especially in rural areas, did not receive breastfeeding advice or assistance during the pregnancy or on the follow-up visit (25% in urban and 50% in rural areas).

Too early, too many and too closely spaced pregnancies increase the mortality and morbidity risk for mother and child. Despite this, only 25% of the rural women received information about how to avoid pregnancy. Only 2 of the rural facilities offer family planning services and contraceptive drugs. The situation is better in urban areas where almost 70% of the facilities offer these services. However, there is clearly an unmet need for family planning services in both urban and rural locations. Three in four women say they want more information on how to avoid pregnancy.

INEQUALITIES BETWEEN WEALTH GROUPS

There are substantial inequalities in health service utilization between wealth groups. The poor use health services to a much lesser extent than the rich.

Figure 3: Utilization of services by wealth quintile

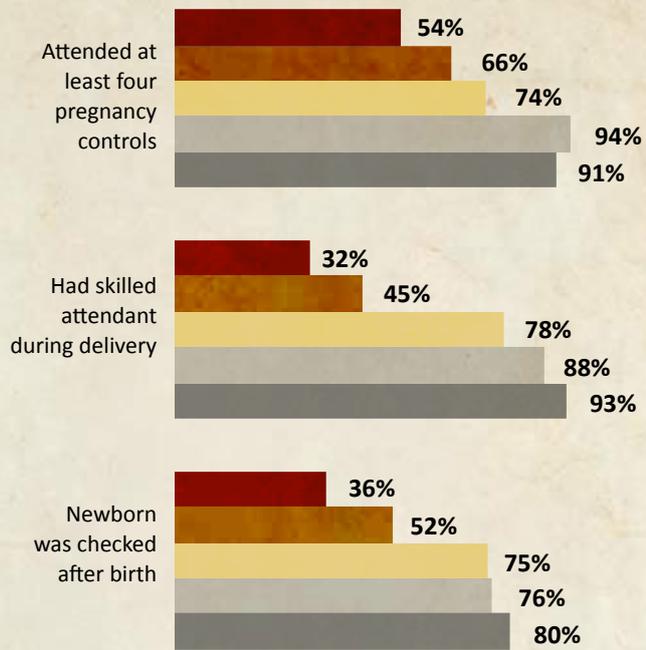
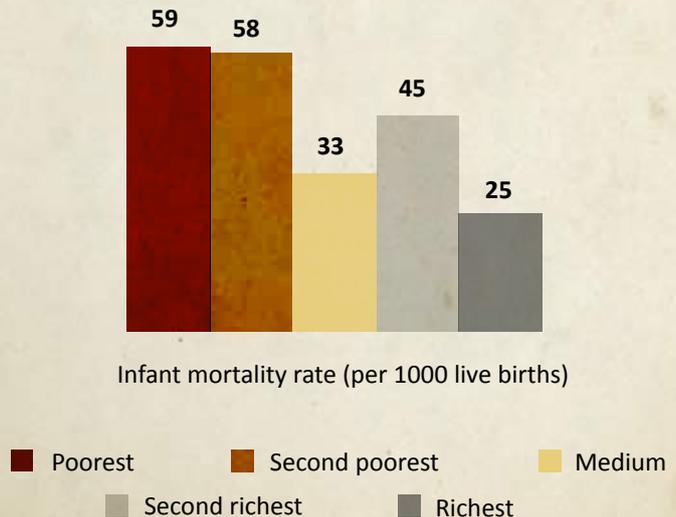


Figure 4: Infant mortality rate by wealth quintile



We constructed a wealth index based from information about household asset ownership and building materials and divided the sample into wealth quintiles. Figure 3 shows variations in utilization of pregnancy controls, skilled attendants and follow-up visits for newborns across wealth groups.

The most important service, skilled attendance, is the one that exhibits the strongest socio-economic gradient. Three

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Author: Ingrid Hoem Sjørnsen.

Editor: Ingvild Hestad. Copy editor: Lisa Arnestad.

times as many women had a skilled attendant in the richest group compared to the poorest.

Most of the poor households reside in rural areas and, as we have seen above, they have worse access to health services than the rich.

The least wealthy also have higher mortality rates among infants (fig 4). The mortality differentials are probably related to the lower utilization of health services in the poorer groups. Another contributory factor is that the poor are more frequently exposed to health risks, such as contaminated water and inadequate sanitation, than the rich. This underlines an important point: the availability and utilization of maternal and child health services is the worst in the parts of the population that need them the most. The rural poor are the group with the most urgent need for improvements in health and health services.

CONCLUSIONS/RECOMMENDATIONS

Availability and utilization of essential maternal and newborn health services is far from universal in the surveyed areas.

Childbirth services have the largest potential to save maternal and newborn lives, but exhibits the largest shortages. The low utilization of skilled attendance in rural areas, and the poor availability of emergency obstetric care in general, are particularly critical issues.

To increase the number of women who receive skilled attendance during delivery should be a priority for the Health Ministry if they want to reduce maternal and newborn mortality.

Measures must take both physical availability and household perceptions into account.

Availability of services can be improved by:

1. Better referral and more intensive use of the facilities that already offers delivery services
2. Increase in the number of facilities that offer delivery services

Household preferences might be affected by information campaigns about the advantages of skilled attendants and through improving the quality of the services. For instance, measures could be taken to make women feel more comfortable in the facilities.

Essential drugs and services to handle childbirth complications should be available at all facilities that offer delivery services.

Shortage of drugs, particularly drugs to stop bleeding after birth, is the most critical shortage in health centers and health posts when it comes to childbirth services. Equipping all health facilities with the recommended basic drug kit (including essential drugs like antibiotics, anti-malarials and oxytocin) would improve the quality of health facilities and the ability of health workers to save lives drastically.

Efforts to reduce maternal and newborn mortality should target the poor.

To achieve substantial reductions in mortality, particular attention must be paid to how to reach the poor.

The high utilization of antenatal care services in Angola shows that it should be possible to scale up other services. Skilled attendance and emergency obstetric care require more resources in terms of equipment, drugs and skilled workers. The health survey shows that there is an urgent need for such improvements in these essential services to save lives.