Free care for deliveries and caesareans in West Africa and Morocco: research findings and lessons

OVERVIEW

This brief summarises some of the main conclusions and lessons from multi-disciplinary evaluations of four national policies to increase access to obstetric care in Burkina Faso, Benin, Mali and Morocco. These countries have all introduced universal subsidy or exemption policies targeting deliveries (in some cases) and caesareans in the last decade. The FEMHealth project used a variety of research tools to understand the origins, financing, implementation and effects of these policies, focussing not only on utilisation, health gains and financial protection but also on impacts on the wider health system and any unintended effects.

Some notable strengths were found across the countries. There is considerable political commitment to these policies and to maintaining the gains they have generated. They have been relatively thoroughly implemented, without the budget shortfalls which have been documented in other settings. They have also, in some cases, like Morocco's, been accompanied by the additional supply-side improvements which are required. Our research also found an underlying support for them, not only from beneficiaries but also from key actors within the health system (health district managers, hospital management teams, specialists, nurses and midwives). The policies were generally considered to be relevant and

KEY MESSAGES

- A broad package of care should be exempted if the goal is improved maternal and neonatal health. Policies which focus on caesareans alone cannot address the main causes of death and disability
- Exemption and subsidy policies can provide financial protection if well designed and implemented.
- There are high risks of favouring better off households unless exemption policies are accompanied by concerted efforts to address other barriers (physical, cultural and related to perceptions of quality of care)
- Improvements in quality – particularly in relation to newborn care and also in terms of improving the experience of women who deliver – are crucial, both to increasing use of services and making them effective
- The right payment systems must be in place (to cover costs but also reward efficiency), but so must effective regulation of facilities and staff, to prevent illegal passing on of costs to users
- Clear communication, involvement of stakeholders, including providers, and enabling effective stewardship of the local health system are all critical to policy and wider health service effectiveness

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important. In some cases, they also appeared to generate efficiency savings.

However, the heavy emphasis of these policies on caesareans (in two out of four countries) has been problematic in a number of ways: caesareans can save lives, but even if utilisation increases it is not easy to know if the right (medically indicated) women have received care. Moreover, the use of caesareans is heavily skewed to the rich and to urban areas, meaning that the benefits of the funding will almost automatically be biased in favour of the rich. It is an intervention which in some contexts needs boosting, but in other contexts (or for some groups) needs controlling. It can be induced by suppliers and patients for the wrong reasons, and carries medical risks.

Moreover, in other countries, where fixed payments to facilities were high and where onward charges to women continued illegally under the policy, the main winners were the hospitals, which gained financially from the policy. Unfortunately there was limited evidence of this being used to improve the overall quality of care or to strengthen the health system as a whole.

We have found a range of outcomes in different contexts (positive and negative across different sites within the same country). This underlines the importance not just of policy design but also context and the institutional and organisational frameworks into which policies are introduced.

SYNTHESIS OF LEARNING

Main Problems:

There is a growing consensus that maternal health outcomes can only be improved through policies and programmes that combine interventions to address the different causes of ill health and target multiple groups. Such policies and programmes are complex in nature as they involve coordination between different tiers in the health system and multiple actors including communities, health workers and managers. User fee exemption for delivery and emergency obstetric care (EmONC) is one such policy that has been introduced by many countries in Africa and globally with the aim of improving access to care and thus improving maternal and neonatal outcomes. However, the current evidence base regarding the impact of this policy is not well developed, in part because of evaluation designs that are not able to capture all the necessary information for policy-makers to make informed decisions. The FEMHealth project (2011-14) aimed to reduce this gap by developing research methodologies and tools that would lead to enhanced research on policy implementation, stronger evidence and improved dissemination.

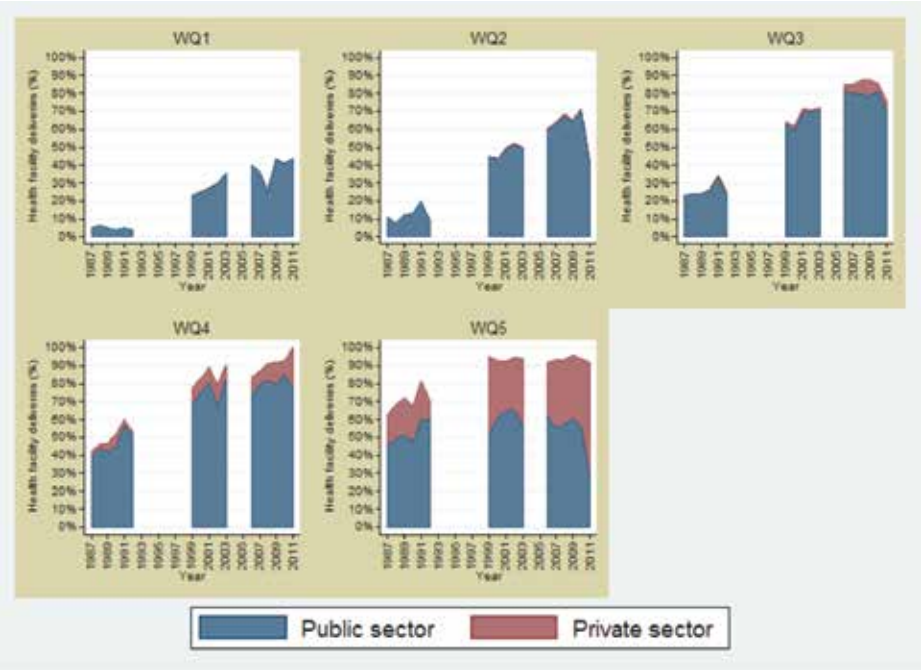

Figure 1. Trend in deliveries taking place in public and private sector facilities stratified by relative wealth, in Morocco, 1987-2011 (DHS data)

Methods:

The findings presented in this report are taken from 14 main research tools, most of which were used in all four study countries. They used mixed methods and included: document review; interviews with key informants at international, national and district level; analysis of routine financial and health information, as well as of secondary survey data; structured extraction from medical files; surveys of patients and staff; in-depth interviews with patients and observation of care processes. Conceptual frameworks linking all of these components were developed at the start of the programme and helped to integrate results.

Within each country, 4-6 study sites were chosen using criteria relating to minimum samples, but also a range of contextual criteria including poverty rates, utilisation levels, and distribution of population - the aim being to include a variety of contexts, including areas with higher barriers of poverty and low utilisation as well as ones where access was better prior to the policy introduction.

In order to study effects, FEMHealth used previous studies, where available, and time trend analysis. We also used cross-sectional analysis to understand how differences in outcomes might link to differences in implementation of the policies. Our overall approach was to construct a plausible narrative of policy introduction, implementation and effects, based on a triangulation of different sources and methods, and to observe any patterns across the different sites and contexts.

Main Findings:

1. All three countries (recent data was lacking for Mali) have seen increasing access over time, and while the policies may have contributed to their continuation into the current period, they have not apparently accelerated that trend
2. Analysis of changing utilisation by socio-economic group shows a narrowing of inequalities for all three countries with survey data. Again, this is part of a longer term trend and relates in part to the prior high supervised delivery rates of higher income quintiles. It is not possible to quantify the role of the

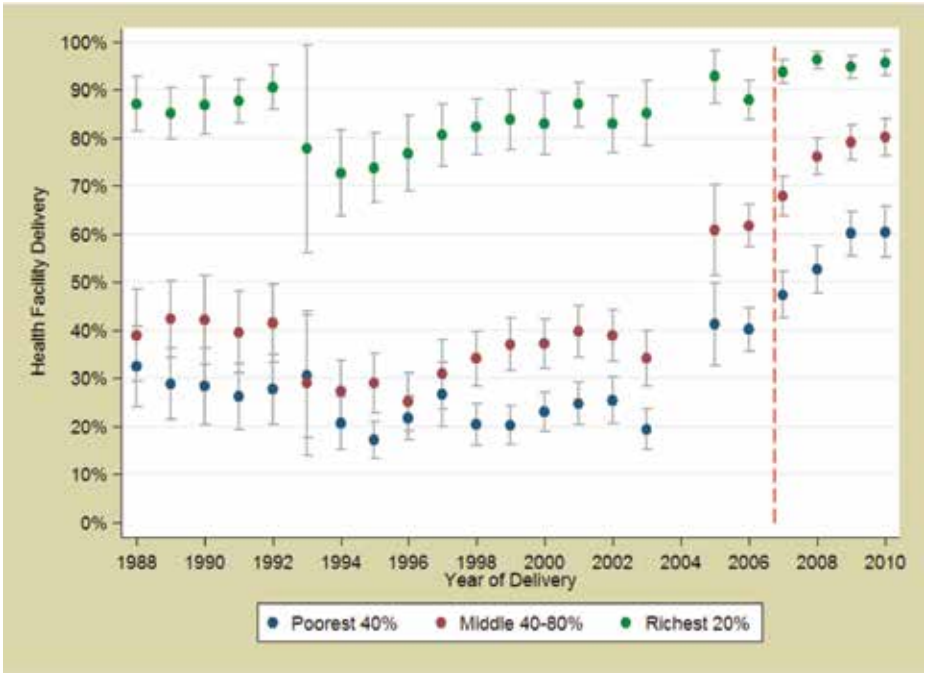

Figure 2 Trend in health facility deliveries stratified by relative wealth, in Burkina Faso, 1988-2010 (DHS data)

policies, though they are likely to have contributed to some extent

3. The overall evidence suggests a significant reduction in household payments for the targeted services, ranging from 60 to 90%, depending on the delivery type and country
4. However, even in relation to the package of care which was supposed to be covered, households continued to pay sums which amounted to a varying proportion of their overall expenditure (small in Morocco, intermediate in Burkina and Benin and substantial in Mali)
5. Cross-sectional analysis shows that quality of care is variable across sites and that there is no evidence that those hospitals which are implementing the policy effectively are providing worse care. In some cases, such as the Burkina Faso sites, it is the opposite pattern
6. There were no systematic effects on the wider health system or on untargeted services
7. From a financial perspective, the financial burden of the policies is manageable. They cost 2.5-3.5% of public health expenditure in 2011, and were funded from national resources.

Discussion/analysis of the findings:

The policies are relatively recent and it is early to make a final judgement on this question, but in general, they are likely to have played a part in supporting continued improvements, along with other changes and investments. In the case of Morocco, for example, there were a number of parallel investments within the overall Action Plan and many households prior to the policy benefited from a card providing exemption from all payments for low income households. In this context it would not be expected that the free delivery care at hospitals would lead to a dramatic shift in behaviour. Rather, it should be seen as part of a continuum of measures to increase facility deliveries over time.

The policies are universal in design and should benefit all women. However, non-financial barriers are more significant for women in rural areas, particularly in relation to transport. Moreover, the policies support those who use the services, which in all countries were skewed towards the better off households before the policies (especially for caesareans).

Changing that means changing care-seeking behaviour at delivery, which as our research has shown is quite a difficult task, especially over the short term. This requires raising awareness of the policies, especially amongst non-users and more remote women, improved physical access and reassuring women in relation to their reception, the costs they will face and the support they will receive during deliveries.

Evidence suggests that all of these require more effective actions in the study countries. A significant proportion (0-35%, depending on site) was unable to pay, even after policy implementation. Moreover, women reported a lack of certainty about what they should pay or not, which not only increases financial problems but also clouds the relationship with providers. This indicates that there is plenty of scope to increase the financial protection offered by the policies. For example, in Burkina Faso, the payment of the residual 20% for indigents remains to be implemented.

The case studies found that the targeted policies have not created opportunities to strengthen the stewardship function, or at least, these opportunities have not been taken. This may present a challenge beyond the scope of a single national policy.

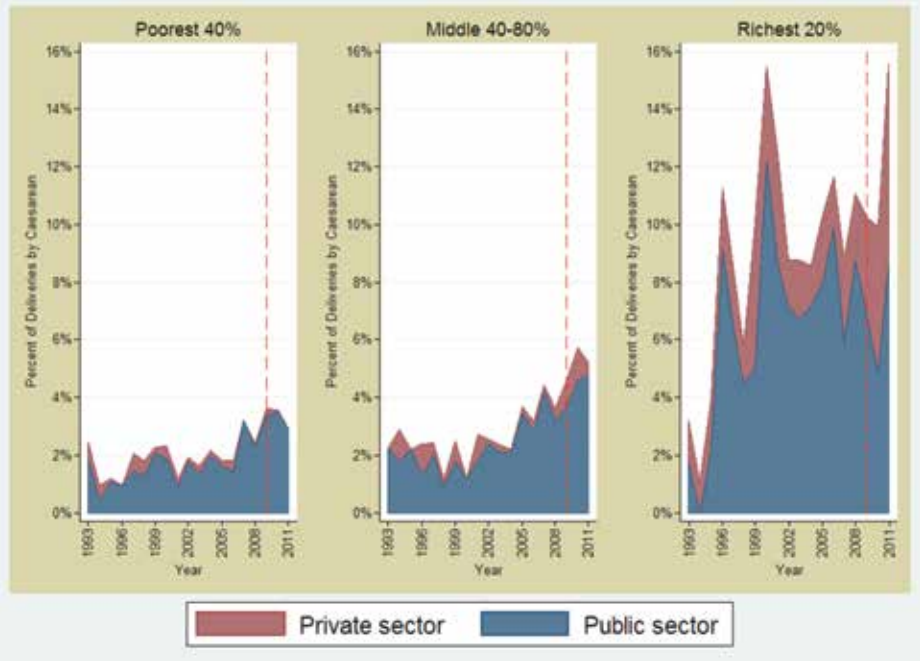

Figure 3 Trend in caesarean sections taking place in public and private sector facilities stratified by relative wealth, in Benin, 1993-2012 (DHS data)

Recommendations:

1. Governments should extend exemption and subsidy policies but should ensure that they cover a package of care which addresses all of the main causes of maternal and neonatal morbidity and mortality
2. They should work with providers to raise the quality of care provided, particularly for the newborn, and not neglecting the interpersonal skills which are so important to users
3. Policies need to be clearly communicated to health staff and the community
4. Provider payments need to be correctly calibrated so as to create the right incentives
5. Managers, staff and communities should be involved in developing and monitoring the policy in order to increase ownership and control abuse
6. All countries need to more effectively regulate providers to stop illicit payments from being demanded of patients
7. Additional actions are needed to ensure that benefits can be equitable – in particular, paying attention to transport and access to facilities at night
8. Underlying systemic weaknesses which undermine policy effectiveness need to be addressed. These include, for example, drugs supply and distribution systems which are not reliable and poor provider-patient relationships.
9. There should be a focus on enabling stewardship at the local level by reinforcing competences and setting up institutional arrangements to enable effective management of resources.
10. All exemption and financial protection policies should be embedded in an overall national plan to achieve universal health coverage, and should not add to the fragmentation of the health financing architecture.

For further information, please contact the scientific coordinator, Dr Sophie Witter, at the University of Aberdeen: s.witter@abdn.ac.uk and visit the project website: www.abdn.ac.uk/femhealth.

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